

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03841

3848

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>4 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Annapolis, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Angela</u> Middle <u>Leigh</u> Last <u>ALLEN</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>23</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-19-59</u>	
9. AGE (In years last birthday) yrs. <u>4</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Sidney Ethan ALLEN III</u>				14. MOTHER'S MAIDEN NAME <u>Marilyn Joanna FLOYD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>U.S. Naval Hospital, Annapolis, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pre Intracranial Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) <u>---</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u> INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>4-23</u> , 19 <u>59</u> , to <u>4-23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-23</u> , 19 <u>59</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Annapolis, Md.</u> DATE SIGNED <u>4-24-59</u>							
ACTUAL SIGNATURE <u>F. M. Kenny</u>				M.D. <u>U.S. Naval Hospital, Annapolis, Md.</u>			
PHYSICIAN'S NAME (Type) <u>F. M. KENNY LT MC USNR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-25-59</u>		<u>All Hallows Chapel</u>		<u>Davidsonville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>				ADDRESS <u>San Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 27 59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Charles E. Huns</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3874 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03842

Reg. Dist. No.

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>A.A.</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Sage</b> b. COUNTY <b>Sage</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dorsey</b>		c. LENGTH OF STAY IN 1b <b>6 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sage</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box 214, Forest Ave.</b>				d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) <b>Sharron Kay Barker</b>			4. DATE OF DEATH <b>April 23 19 59</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/10/59</b>		9. AGE (In years last birthday) <b>2 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Cleveland, Ohio.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Roger Barker</b>			14. MOTHER'S MAIDEN NAME <b>Joyce Diane Edwards</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mr. and Mrs. Roger Barker (Parents).</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suffocation</b> <b>9240</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Baby was found dead in her crib with her head buried in a (a soft pillow.</b>			
20c. TIME OF INJURY Month, Day, Year <b>6 A.M. 4/23/59 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Dorsey</b>		20g. (County) <b>A.A. Md.</b>		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Gustave H. Faubert</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>4/23/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>4-24-59</b>		22c. NAME OF CEMETERY OR CREMATORY	
				22d. LOCATION (City, town, or county) (State) <b>Cleveland, Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>			24a. REC'D BY REGISTRAR <b>APR 27 59</b>		24b. REGISTRAR'S SIGNATURE <i>Charles L. Hume</i>

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FOR STATE  
HEALTH DEPT.

03842

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
POSTAL MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED J. J. JONES		AGE 45	SEX M	RACE W	DATE OF BIRTH 1-1-1900
PLACE OF BIRTH BALTIMORE, MD.		DATE OF DEATH 1-15-1945	TIME OF DEATH 10:00 AM	PLACE OF DEATH HOME	CAUSE OF DEATH HEART DISEASE
DISEASE OR INJURY CORONARY ARTERY DISEASE		MANNER OF DEATH NATURAL			
SIGNATURE OF EXAMINER J. J. JONES		DATE 1-15-1945			
LOCALITY BALTIMORE, MD.		COUNTY BALTIMORE			
STATE MD.		FEDERAL BUREAU OF INVESTIGATION U. S. DEPARTMENT OF JUSTICE			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05066

3875  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY in 1b <b>11 months</b> <b>7 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>611 Cumberland Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Barnett</b> Last <b>Barnett</b>		4. DATE OF DEATH Month <b>4</b> Day <b>21</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6/21/84</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>21</b> Hours <b>19</b> Min.	11. IF UNDER 24 HRS. Months <b>7</b> Days <b>21</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Barnett</b>		14. MOTHER'S MAIDEN NAME <b>Sarah</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>110-09-9050</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Bronchopneumonia</b> <b>177x</b> DUE TO Metastatic Cancer in the lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cancer of Prostate</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ----- 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from <b>5/14</b> , 19 <b>58</b> , to <b>4/21</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>4/21</b> , 19 <b>59</b> , and that death occurred at <b>7:35 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>4/21/59</b> ACTUAL SIGNATURE <b>L. Benedict, M. D.</b> PHYSICIAN'S NAME (Type) <b>Crownsville State Hospital, Md.</b> <b>4/21/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>4/24/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Ignace Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas G. Cooper</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 11 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

105000

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

25

105000

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of medical examiner		11. Signature of coroner		12. Signature of jury	
13. Signature of witness		14. Signature of witness		15. Signature of witness		16. Signature of witness	
17. Signature of witness		18. Signature of witness		19. Signature of witness		20. Signature of witness	
21. Signature of witness		22. Signature of witness		23. Signature of witness		24. Signature of witness	
25. Signature of witness		26. Signature of witness		27. Signature of witness		28. Signature of witness	
29. Signature of witness		30. Signature of witness		31. Signature of witness		32. Signature of witness	
33. Signature of witness		34. Signature of witness		35. Signature of witness		36. Signature of witness	
37. Signature of witness		38. Signature of witness		39. Signature of witness		40. Signature of witness	
41. Signature of witness		42. Signature of witness		43. Signature of witness		44. Signature of witness	
45. Signature of witness		46. Signature of witness		47. Signature of witness		48. Signature of witness	
49. Signature of witness		50. Signature of witness		51. Signature of witness		52. Signature of witness	
53. Signature of witness		54. Signature of witness		55. Signature of witness		56. Signature of witness	
57. Signature of witness		58. Signature of witness		59. Signature of witness		60. Signature of witness	
61. Signature of witness		62. Signature of witness		63. Signature of witness		64. Signature of witness	
65. Signature of witness		66. Signature of witness		67. Signature of witness		68. Signature of witness	
69. Signature of witness		70. Signature of witness		71. Signature of witness		72. Signature of witness	
73. Signature of witness		74. Signature of witness		75. Signature of witness		76. Signature of witness	
77. Signature of witness		78. Signature of witness		79. Signature of witness		80. Signature of witness	
81. Signature of witness		82. Signature of witness		83. Signature of witness		84. Signature of witness	
85. Signature of witness		86. Signature of witness		87. Signature of witness		88. Signature of witness	
89. Signature of witness		90. Signature of witness		91. Signature of witness		92. Signature of witness	
93. Signature of witness		94. Signature of witness		95. Signature of witness		96. Signature of witness	
97. Signature of witness		98. Signature of witness		99. Signature of witness		100. Signature of witness	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT

RE, 18

3876

## CERTIFICATE OF DEATH

Reg. Dist. No. 03843

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore City</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CROWNSVILLE</u>		c. LENGTH OF STAY IN 1b <u>3y 2mo 4day</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CROWNSVILLE STATE HOSPITAL</u>		d. STREET ADDRESS <u>574 W. HOFFMAN STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>BEARD</u> Last <u>BEARD</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-28-05</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jesse Beard</u>		14. MOTHER'S MAIDEN NAME <u>MARY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Hospital Records</u> Address <u>-----</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL PNEUMONIA</u> <u>150X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MALIGNANCY OF OESOPHAGUS</u> DUE TO (c) <u>-----</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dehydration</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2-3 mos</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>-----</u> p. m. <u>-----</u> 19 <u>59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>		20f. (City or town) <u>-----</u> (County) <u>-----</u> (State) <u>-----</u>	
21. I certify that I attended the deceased from <u>2-8</u> , 19 <u>58</u> to <u>APRIL 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 12</u> , 19 <u>59</u> , and that death occurred at <u>1:23 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leonardo Garcia</u> M.D.		ADDRESS (Street, city or town, state) <u>CROWNSVILLE STATE HOSPITAL</u> DATE SIGNED <u>4/12/59</u>	
PHYSICIAN'S NAME (Type) <u>Leonardo Garcia, M. D.</u>		<u>CROWNSVILLE, Md.</u> <u>4/12/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/18/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halstead - March 4 1958</u> ADDRESS <u>915 David Hill Ave</u>		24a. REC'D BY REGISTRAR DATE <u>APR 16 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Brown</u>			

# MONTANA STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____		RACE _____	
DATE OF BIRTH _____		PLACE OF BIRTH _____		COUNTY _____	
DATE OF DEATH _____		PLACE OF DEATH _____		COUNTY _____	
TIME OF DEATH _____		CAUSE OF DEATH _____		MANNER OF DEATH _____	
SIGNATURE OF DECEASED _____		SIGNATURE OF WITNESS _____		SIGNATURE OF PHYSICIAN _____	
SIGNATURE OF CLERK _____		SIGNATURE OF JUDGE _____		SIGNATURE OF SHERIFF _____	
SIGNATURE OF NOTARY _____		SIGNATURE OF CHURCH CLERK _____		SIGNATURE OF SCHOOL TEACHER _____	
SIGNATURE OF POSTMASTER _____		SIGNATURE OF TOWN CLERK _____		SIGNATURE OF COUNTY CLERK _____	
SIGNATURE OF STATE CLERK _____		SIGNATURE OF FEDERAL CLERK _____		SIGNATURE OF NATIONAL CLERK _____	



This certificate is to be filled out by the physician or other qualified person who has attended the deceased. It should be filled out as soon as possible after death, and should be filed in the office of the county clerk. A copy of this certificate should be sent to the state department of health.

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3849

CERTIFICATE OF DEATH

03844

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Maryland</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>Ann</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Anne Arundel General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elvaton (Millersville, P.O. D.)</u> d. STREET ADDRESS <u>Severn Rd., Rt. 1-Box 266</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>"Baby" Boy</u> Middle <u>Beatty</u> Last <u>(Beatty)</u>		4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 28, 1959</u>
9. AGE (In years lost birthday) yrs. <u>3</u>		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>15</u>	11. IF UNDER 24 HRS. <u>45</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Am.</u>	
13. FATHER'S NAME <u>James Dewey Beatty</u>		14. MOTHER'S MAIDEN NAME <u>Dolores Joan Buckley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mother</u>		Address <u>Elvaton, Millersville P.O., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <u>None</u> DUE TO (c) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>11:30</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 28</u> , 19 <u>59</u> , to <u>April 28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 28</u> , 19 <u>59</u> , and that death occurred at <u>11:30</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edmund G. Bennett</u>		DATE SIGNED <u>4-29-59</u>	
PHYSICIAN'S NAME (Type) <u>Glen Burnie, Md.</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 4, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Singleton</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
ADDRESS <u>Glen Burnie, Md.</u>		DATE <u>MAY 4 '59</u>	

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100-111111-100  
CONFIDENTIAL  
200-111111-100

3443

CERTIFICATE OF DEATH

100-111111-100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G241 4/10/59 fcy

CERTIFICATE OF DEATH

03845

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arundel</u>		c. LENGTH OF STAY IN TB <u>3 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arundel</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Arundel</u>				d. STREET ADDRESS <u>Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Dorothy Irene Bell</u>				4. DATE OF DEATH <u>April 5 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 19 1892</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Ernest Albright</u>				14. MOTHER'S MAIDEN NAME <u>Annie C. Dahl</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Charles W. Bell</u> Address <u>Same as I</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 260X DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1959</u> , 19 <u>59</u> , to <u>1959</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-2-59</u> , 19 <u>59</u> , and that death occurred at <u>4 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Severna Park Md</u> DATE SIGNED <u>4-5-59</u>							
ACTUAL SIGNATURE <u>Robert R. HAHN</u> M.D.				PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 8, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping &amp; Kirkley, Glen Burnie, Md.</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR <u>APR 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3878

## CERTIFICATE OF DEATH

03846

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>12 years</b> <b>10 mo. 20 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severn</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>Route 2 Box 62</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lottie</b> Middle <b>M</b> Last <b>Bennerman</b>			4. DATE OF DEATH Month <b>4</b> Day <b>14</b> Year <b>1959</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/2/1898</b>		9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundry Worker</b>			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Bilups</b>			14. MOTHER'S MAIDEN NAME <b>Ella</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cachexia</b> <b>170x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Cancer of the lungs &amp; Abdominal Organs</b> DUE TO (c) <b>Cancer of Right Breast</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>5/24</b> , 19 <b>46</b> , to <b>4/14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>4/24</b> , 19 <b>59</b> , and that death occurred at <b>1:30 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>[Signature]</i>		ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b>				DATE SIGNED <b>4/14/59</b>	
PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>		Crownsville State Hospital, Md.				<b>4/14/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4-18-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Auburn</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore 30, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Isaiah L. Brown + Son</b>				ADDRESS <b>108 W. Montgomery St.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 17 '59</b>	
				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

3-28

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of medical examiner		12. Signature of coroner	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of hospital		17. Signature of nursing home		18. Signature of other institution	
19. Signature of family		20. Signature of friends		21. Signature of neighbors	
22. Signature of community		23. Signature of church		24. Signature of school	
25. Signature of other		26. Signature of other		27. Signature of other	
28. Signature of other		29. Signature of other		30. Signature of other	
31. Signature of other		32. Signature of other		33. Signature of other	
34. Signature of other		35. Signature of other		36. Signature of other	
37. Signature of other		38. Signature of other		39. Signature of other	
40. Signature of other		41. Signature of other		42. Signature of other	
43. Signature of other		44. Signature of other		45. Signature of other	
46. Signature of other		47. Signature of other		48. Signature of other	
49. Signature of other		50. Signature of other		51. Signature of other	
52. Signature of other		53. Signature of other		54. Signature of other	
55. Signature of other		56. Signature of other		57. Signature of other	
58. Signature of other		59. Signature of other		60. Signature of other	
61. Signature of other		62. Signature of other		63. Signature of other	
64. Signature of other		65. Signature of other		66. Signature of other	
67. Signature of other		68. Signature of other		69. Signature of other	
70. Signature of other		71. Signature of other		72. Signature of other	
73. Signature of other		74. Signature of other		75. Signature of other	
76. Signature of other		77. Signature of other		78. Signature of other	
79. Signature of other		80. Signature of other		81. Signature of other	
82. Signature of other		83. Signature of other		84. Signature of other	
85. Signature of other		86. Signature of other		87. Signature of other	
88. Signature of other		89. Signature of other		90. Signature of other	
91. Signature of other		92. Signature of other		93. Signature of other	
94. Signature of other		95. Signature of other		96. Signature of other	
97. Signature of other		98. Signature of other		99. Signature of other	
100. Signature of other		101. Signature of other		102. Signature of other	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3879

## CERTIFICATE OF DEATH

03847

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft George G. Meade</u>		c. LENGTH OF STAY IN 1b <u>Severn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Army Hospital</u>		d. STREET ADDRESS <u>Bxo 18, Route #1</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Judy</u> Middle <u>L.</u> Last <u>BENNETT</u>		4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>25 March 59</u>
9. AGE (In years last birthday) yrs. <u>9</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u> Hours <u>9</u> Min. <u>9</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Ronald C. Bennett</u>		14. MOTHER'S MAIDEN NAME <u>Betty J. Rowe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Col Ronald C. Bennett, Route 1, Box 18, Severn, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Etiology undetermined</u> <u>795.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Approx 4 to 6 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>-</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased <u>xxx</u> at <u>0615 AM</u> , <u>19</u> to <u>4 April</u> , <u>19 59</u> , that I last saw the deceased <u>xxx</u> on <u>DOA</u> , <u>19</u> , and that death occurred at <u>0615 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Army Hospital, Ft Meade, Md</u> <u>4 April 59</u>			
ACTUAL SIGNATURE <u>Raymond J. Gould Capt MC</u>		M.D. <u>U.S. Army Hospital, Ft Meade, Md</u>	
PHYSICIAN'S NAME (Type) <u>RAYMOND J. GOULD, CAPT, MC</u>		<u>U.S. ARMY HOSPITAL, FT MEADE, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr 6, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Nichols</u>	22d. LOCATION (City, town, or county) (State) <u>Nichols, New York</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley, Gle n Burnie Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 7 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Cathryn L. Lewis</u>			

2050234XV5



3880  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn Park</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn Park</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>5624 Ballman Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>FRANKLIN EARL BERRY</b>				4. DATE OF DEATH <b>April 12, 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 27, 1884</b>	
9. AGE (In years lost birthday) <b>74</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Spring Rigger</b>		11. BIRTHPLACE (State or foreign country) <b>Green Bay, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Earl L. Berry</b> Address <b>5624 Ballman Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>162.1</b> <b>Branchogenic Cardiovascular</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs?</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-16</b> , 19 <b>55</b> , to <b>7-11</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7-11</b> , 19 <b>59</b> , and that death occurred at <b>10:56</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>Y. J. S. S.</b>							
ACTUAL SIGNATURE <b>Henry G. Summers</b> M.D.				PHYSICIAN'S NAME (Type) <b>Henry G. Summers</b> <b>1401 Patapsco Ave. Balto. 25, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 15, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Pk.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Reginald Ronce</b>				ADDRESS <b>4001 Ritchie Hwy.</b>		24a. REG'D BY REGISTRAR DATE <b>APR 17 59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Rouse</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1920

1. NAME OF DECEASED		2. SEX		3. AGE		4. PLACE OF BIRTH	
JAMES H. HARRIS		Male		45		New York City	
5. OCCUPATION		6. MARITAL STATUS		7. COLOR		8. RACE	
Clerk		Married		White		Caucasian	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH	
April 15, 1920		10:30 AM		Home		Heart Disease	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF MINISTER	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF WITNESS		19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF MINISTER	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF WITNESS		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF MINISTER	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF WITNESS		27. SIGNATURE OF PHYSICIAN		28. SIGNATURE OF MINISTER	
29. SIGNATURE OF DECEASED		30. SIGNATURE OF WITNESS		31. SIGNATURE OF PHYSICIAN		32. SIGNATURE OF MINISTER	
33. SIGNATURE OF DECEASED		34. SIGNATURE OF WITNESS		35. SIGNATURE OF PHYSICIAN		36. SIGNATURE OF MINISTER	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF WITNESS		39. SIGNATURE OF PHYSICIAN		40. SIGNATURE OF MINISTER	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF WITNESS		43. SIGNATURE OF PHYSICIAN		44. SIGNATURE OF MINISTER	
45. SIGNATURE OF DECEASED		46. SIGNATURE OF WITNESS		47. SIGNATURE OF PHYSICIAN		48. SIGNATURE OF MINISTER	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF WITNESS		51. SIGNATURE OF PHYSICIAN		52. SIGNATURE OF MINISTER	
53. SIGNATURE OF DECEASED		54. SIGNATURE OF WITNESS		55. SIGNATURE OF PHYSICIAN		56. SIGNATURE OF MINISTER	
57. SIGNATURE OF DECEASED		58. SIGNATURE OF WITNESS		59. SIGNATURE OF PHYSICIAN		60. SIGNATURE OF MINISTER	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF WITNESS		63. SIGNATURE OF PHYSICIAN		64. SIGNATURE OF MINISTER	
65. SIGNATURE OF DECEASED		66. SIGNATURE OF WITNESS		67. SIGNATURE OF PHYSICIAN		68. SIGNATURE OF MINISTER	
69. SIGNATURE OF DECEASED		70. SIGNATURE OF WITNESS		71. SIGNATURE OF PHYSICIAN		72. SIGNATURE OF MINISTER	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF WITNESS		75. SIGNATURE OF PHYSICIAN		76. SIGNATURE OF MINISTER	
77. SIGNATURE OF DECEASED		78. SIGNATURE OF WITNESS		79. SIGNATURE OF PHYSICIAN		80. SIGNATURE OF MINISTER	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF WITNESS		83. SIGNATURE OF PHYSICIAN		84. SIGNATURE OF MINISTER	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF WITNESS		87. SIGNATURE OF PHYSICIAN		88. SIGNATURE OF MINISTER	
89. SIGNATURE OF DECEASED		90. SIGNATURE OF WITNESS		91. SIGNATURE OF PHYSICIAN		92. SIGNATURE OF MINISTER	
93. SIGNATURE OF DECEASED		94. SIGNATURE OF WITNESS		95. SIGNATURE OF PHYSICIAN		96. SIGNATURE OF MINISTER	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF WITNESS		99. SIGNATURE OF PHYSICIAN		100. SIGNATURE OF MINISTER	

1. Name of deceased  
2. Sex  
3. Age  
4. Place of birth  
5. Occupation  
6. Marital status  
7. Color  
8. Race  
9. Date of death  
10. Time of death  
11. Place of death  
12. Cause of death  
13. Signature of deceased  
14. Signature of witness  
15. Signature of physician  
16. Signature of minister  
17. Signature of deceased  
18. Signature of witness  
19. Signature of physician  
20. Signature of minister  
21. Signature of deceased  
22. Signature of witness  
23. Signature of physician  
24. Signature of minister  
25. Signature of deceased  
26. Signature of witness  
27. Signature of physician  
28. Signature of minister  
29. Signature of deceased  
30. Signature of witness  
31. Signature of physician  
32. Signature of minister  
33. Signature of deceased  
34. Signature of witness  
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44. Signature of minister  
45. Signature of deceased  
46. Signature of witness  
47. Signature of physician  
48. Signature of minister  
49. Signature of deceased  
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85. Signature of deceased  
86. Signature of witness  
87. Signature of physician  
88. Signature of minister  
89. Signature of deceased  
90. Signature of witness  
91. Signature of physician  
92. Signature of minister  
93. Signature of deceased  
94. Signature of witness  
95. Signature of physician  
96. Signature of minister  
97. Signature of deceased  
98. Signature of witness  
99. Signature of physician  
100. Signature of minister

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03848

Reg. Dist. No.

3881

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balti. Co.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 25</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 27-0351.2</u> ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Belgrove Rd. Gravel Pit.</u>			d. STREET ADDRESS <u>4202 Hollins Ferry Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Wallace Eugene Berry</u>			4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1959</u>		
5. SEX <u>m</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/9/42</u>		9. AGE (In years last birthday) <u>17</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unem. stock clk.</u>		11. BIRTHPLACE (State or foreign country) <u>Balti. Co.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Edw. Berry</u>			14. MOTHER'S MAIDEN NAME <u>Pauline Withrow</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>21240 2905</u>		17. INFORMANT <u>Chas. Sereck</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning - 929.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>stating the underlying cause lost.</u> DUE TO					INTERVAL BETWEEN ONSET AND DEATH <u>2-5 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Crowned while swimming</u>			
20c. TIME OF INJURY Month, Day, Year <u>4/26 1959</u> Hour <u>4</u> <u>p.m.</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Same as item #1</u>	
		20f. (City or town) <u>Balti. 25</u>		20g. (County) <u>A.A.</u>	
				20h. (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Chas. L. Ball Jr.</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>			ADDRESS <u>4107 Wilkens Ave.</u>		
24a. REC'D BY REGISTRAR DATE <u>APR 28 '59</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>		



FOR STATE  
HEALTH DEPT

Howard H. Hubbard 1101 Wilkins Ave.  
Burial 4/29/59 London Park Cemetery, Baltimore, Maryland

no 21540 2905

known. stock C.K.

17

Eugene

U. S. A.

# Item 20 Film 241 4-14-59 ams **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03850

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A A</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>A.A.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Back Creek</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>C.</i> Last <i>Blaisdell</i>				4. DATE OF DEATH Month <i>4</i> - Day <i>1</i> - Year <i>1959</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct 24-1883</i>	
9. AGE (In years last birthday) <i>75</i> yrs.		IF UNDER 1 YEAR Months <i>7</i> Days <i>1</i> Hours <i>1</i> Min.		IF UNDER 24 HRS. Months <i>7</i> Days <i>1</i> Hours <i>1</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Master at Arms</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Naval Academy</i>		11. BIRTHPLACE (State or foreign country) <i>Stevenspoint Wis.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>John C. Blaisdell</i>				14. MOTHER'S MAIDEN NAME <i>Mary Sundro</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i>				16. SOCIAL SECURITY NO. <i>1904-1916 215-30-4169</i>		17. INFORMANT <i>Mary M. Blaisdell</i> Address <i>(2)</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>850X</i> DUE TO <i>Choking</i> Sudden							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>(b)</i> DUE TO (c) <i>(c)</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell over board at Back Creek</i>			
20c. TIME OF INJURY Month, Day, Year Hour - <i>4-1-59</i> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Back Creek</i>		20f. (City or town) (County) (State) <i>Annapolis A A Co Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. Linhart</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>E. Linhart</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4-4-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Hellerest Comt</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Saylor Sons</i>				ADDRESS <i>Annapolis Md.</i>		24a. REC'D BY REGISTRAR DATE <i>APR 6 '59</i>	
						24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

Item 20b Comm. M.D. 322, 59										
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
3851 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 03851										
1. PLACE OF DEATH a. COUNTY <u>A. A. Co.</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 47X-3</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. ANNIE ARONCE General</u>					d. STREET ADDRESS <u>538-13<sup>th</sup> ST. SE</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Watson</u>		First		Middle		Last		4. DATE OF DEATH Month <u>4</u> Day <u>26</u> Year <u>19 59</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>1/28/23</u>		9. AGE (In years last birthday) <u>36</u> yrs.		
						IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AUTO SALESMAN</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>PENN</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>WATSON ANSTINE BRADLEY</u>					14. MOTHER'S MAIDEN NAME <u>ELISE CARPENTER</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>			16. SOCIAL SECURITY NO. <u>WW II 168-12-2285</u>		17. INFORMANT <u>Mrs. Elsie B. Anstine</u>			Address <u>538-13<sup>th</sup> ST SE WASH. D.C.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Head injury</u> <u>823X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Motor vehicle acc. off roadway</u>							
20c. TIME OF INJURY Month, Day, Year <u>4/26 1959</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>Annapolis</u>		(County) (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>E. Linhart</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>E. Linhart</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>4-30-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington VA.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee Sons</u>					ADDRESS <u>Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	





1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3852

## CERTIFICATE OF DEATH

03852

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>10</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		11182 7th Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A.A. General Hosp.</i>		d. STREET ADDRESS <i>A.A. General Hosp.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>BRYAN David Bryan</i>		4. DATE OF DEATH Month <i>4</i> Day <i>4</i> Year <i>1959</i>	
5. SEX <i>male</i>		6. COLOR OR RACE <i>Col.</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-30-59</i>	
9. AGE (In years lost birthday) yrs. <i>3</i>		10. IF UNDER 1 YEAR Months <i>5</i> Days <i>3</i> Hours <i>15</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Bryan</i>		14. MOTHER'S MAIDEN NAME <i>E. Virginia Galloway</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>John Bryan - Anna, Md.</i>		Address <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>776X</i> DUE TO <i>Prematurity - Weight 1407.2</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>—</i> (c) DUE TO <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/3</i> , 19 <i>59</i> , to <i>4/3</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>4/3</i> , 19 <i>59</i> , and that death occurred at <i>12:10 P</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>95 Catharine St Annapolis Md</i>	
ACTUAL SIGNATURE <i>Philg Price</i>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>William Reese, Jr - Anna, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4-6-59</i>	
22c. NAME OF CEMETERY OR CREMATOR <i>Brewer Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr - Anna, Md.</i>		ADDRESS <i>—</i>	
24a. REC'D BY REGISTRAR <i>APR 7 '59</i>		24b. REGISTRAR'S SIGNATURE <i>William E. Reese</i>	

2063437XV0

03852

CERTIFICATE OF DEATH

3852

*[Faint, illegible handwriting throughout the form, likely bleed-through from the reverse side.]*



**1**  
FOR STATE  
HEALTH DEPT.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**3882**

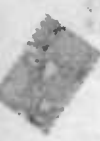
**03853**  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Indiana</b> b. COUNTY <b>Fort Wayne</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linthicum</b>		c. LENGTH OF STAY IN lb <b>8 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Wayne</b> 52 x -3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>570 Forest View</b>			d. STREET ADDRESS <b>3701 Knollcrest Rd.</b>		
3. NAME OF DECEASED (Type or print) <b>ORZA L. BURGNER</b>			4. DATE OF DEATH <b>March April 3rd. 19 59</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/9/90</b>		9. AGE (In years last birthday) <b>68</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Office Clerk (International Harvester Co.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plymouth, Ind.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Christian H. Burgener</b>			14. MOTHER'S MAIDEN NAME <b>Mary Koch</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>309-09-9777</b>		17. INFORMANT Address <b>Mrs. Mabel Burgener (wife).</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Fort Wayne</b> (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Gustave H. Faubert</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>4/3/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bureau</b>		22b. DATE THEREOF <b>Apr. 7, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lindenwood Cem.</b>	
22d. LOCATION (City, town, or county) (State) <b>Fort Wayne, Indiana</b>		24a. REC'D BY REGISTRAR <b>APR 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>		ADDRESS <b>Glen Burnie, Md.</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH



Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Medical History		Previous Illnesses		Family History	
Post-mortem Examination		Findings		Remarks	
Signature of Examiner		Signature of Coroner		Signature of Registrar	
Date		Time		Place	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE LOCAL HEALTH DEPARTMENT, CITY OF BALTIMORE, MARYLAND.

3883

CERTIFICATE OF DEATH

03854

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>AA</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>424 Maple Lane NW</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Louis</b> Middle <b>Fraderick</b> Last <b>Burkman</b>				4. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 4, 1898</b>	
9. AGE (In years last birthday) <b>60 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crain Operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Armour Chem. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William Burkman</b>				14. MOTHER'S MAIDEN NAME <b>Bertha Rex</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>				16. SOCIAL SECURITY NO. <b>215-07-7654</b>			
17. INFORMANT <b>Mrs Edith Burkman, same as 2</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatous</b> <b>163X</b> DUE TO <b>general</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adenocarcinoma of rt. Lung</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan 19 59</b> to <b>April 23 19 59</b> that I last saw the deceased alive on <b>April 23 19 59</b> and that death occurred at <b>9 PM</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>102 B &amp; A Blvd. N.E.</b> DATE SIGNED <b>Glen Burnie, Md.</b>							
ACTUAL SIGNATURE <b>Joseph Taler, M.D.</b>				M.D. <b>Glen Burnie, Md.</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 27, 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping and Kirkley</b>				ADDRESS <b>Glen Burnie, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 28 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





3853

CERTIFICATE OF DEATH

03855

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. A. General Hosp</i>		d. STREET ADDRESS <i>13 Hardesty Ct.</i>	
3. NAME OF DECEASED (Type or print) <i>Elke; Perdella Burrell</i>		4. DATE OF DEATH Month <i>4</i> Day <i>8</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-21-1925</i>
9. AGE (In years last birthday) <i>34</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Corwell Hall Hotel</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Prince Smith</i>		14. MOTHER'S MAIDEN NAME <i>Hollie Day</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-16-9456</i>	
17. INFORMANT <i>Carl E. Burrell-Anna, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>445x</i> DUE TO <i>Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Nephrosis</i> DUE TO <i>Malignant Hypertension</i> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>12 days</i> <i>2/24/59</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2/24</i> , 19 <i>59</i> , to <i>4/8</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>4/8</i> , 19 <i>59</i> , and that death occurred at <i>120</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Theodore H. Johnson</i> M.D. <i>37</i>		ADDRESS (Street, city or town, state) <i>60 West Street</i> DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>DR THEODORE H. JOHNSON</i>		<i>Annapolis, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>4-12-59</i>	<i>Brewer Hill</i>	<i>Annapolis, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr - Anna, Md.</i>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <i>APR 10 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>	

1885

CERTIFICATE OF DEATH

1885



George Washington  
Washington  
U.S. District Court  
District of Columbia  
Filed for Record  
March 1885  
George Washington  
Washington  
U.S. District Court  
District of Columbia  
Filed for Record  
March 1885

George Washington  
Washington  
U.S. District Court  
District of Columbia  
Filed for Record  
March 1885

may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in no event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3884

## CERTIFICATE OF DEATH

03856

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dorsey</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Dorsey</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Thights Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mattie G. Butler</u>				4. DATE OF DEATH <u>Apr. 9</u> 19 <u>59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 24, 1891</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Dorsey, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>M. H. Matthews</u>		14. MOTHER'S MAIDEN NAME <u>Ida Cager</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular heart disease</u> DUE TO (c) <u>Arterial Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec 20</u> , 19 <u>58</u> , to <u>Apr 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Apr 3</u> , 19 <u>59</u> , and that death occurred at <u>4:31</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B B Brumbaugh</u> M.D.				ADDRESS (Street, city or town, state) <u>5609 Main St Dorsey, Md.</u>			
DATE SIGNED <u>4/10/59</u>							
PHYSICIAN'S NAME (Type) <u>B B Brumbaugh</u>				<u>Elbridge 27 M4</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/12/59</u>		<u>St. Rest</u>		<u>Dorsey, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald St. Hill</u> ADDRESS <u>1631 Donald Hill Ave.</u>				24a. REC'D BY REGISTRAR <u>APR 14 59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Robert S. Farns</u>	





Items 5 & 6, Film G241, 4/17/59 fcy  
**CERTIFICATE OF DEATH**

03857

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>2 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>a General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MARY</i> First <i>AMANDA</i> Middle <i>CATTERTON</i> Last		4. DATE OF DEATH <i>April</i> Month <i>9</i> Day <i>1959</i> Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 2 1879</i>
9. AGE (In years last birthday) <i>79</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Bristol Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>James Bussford</i>		14. MOTHER'S MAIDEN NAME <i>MARY WELLS</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cornary embolus -</i> <i>491X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Staphylococcal pneumonia</i> DUE TO (c) <i>staphylococcal infection left hip</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Nov 18, 1958</i> , to <i>April 9, 1959</i> , that I last saw the deceased alive on <i>April 8, 1959</i> , and that death occurred at <i>125P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Emily H. Wilson</i> M.D.		ADDRESS (Street, city or town, state) <i>Lothian, Md.</i> DATE SIGNED <i>4-10-59</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Apr. 11, 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion Meth. Church Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Lothian Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Q. Herderty</i> ADDRESS <i>Salisbury, Md.</i>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
DATE <i>APR 14 59</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filed in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3855

## CERTIFICATE OF DEATH

Item 4 FilmG241 4-27-59 et

Reg. Dist. No. ....

03858

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place) <u>10 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Odenton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A. A. General Hospital</u>				STREET ADDRESS (If rural give location) <u>Box 314 - Washington Ave.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Elizabeth Ann Clark</u>				<b>4. DATE OF DEATH</b> (Month) <u>April</u> (Day) <u>17</u> (Year) <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 5, 1890</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Prince George Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Vermillion</u>				14. MOTHER'S MAIDEN NAME <u>Jenny (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mr. Nicholas S. Clark Same As #2</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
156.2 IMMEDIATE CAUSE (A) <u>Cancer of liver</u>						<u>6 mos</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>primary cancer?</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Deabetes m.</u>						<u>6 mos.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-30-1958</u> , to <u>4-17-1959</u> , that I last saw the deceased alive on <u>4-17-1959</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Frank M. Shuply</u> M.D.				ADDRESS (Street, city, town, state) <u>Annapolis, Md.</u>		DATE SIGNED <u>4-18-59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 20, 1959</u>		NAME OF CEMETERY OR CREMATORY <u>Nichols-Bethel Ch. Cem.</u>		LOCATION (City, town, or county) (State) <u>Odenton Md.</u>	
24. REC'D BY REGISTRAR <u>Arthur S. House</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
DATE <u>APR 20 '59</u>							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3885

CERTIFICATE OF DEATH

03859

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN lb <b>11 months 8 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>15 26-2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Stephen Edward Coles</b>		4. DATE OF DEATH Month <b>4</b> Day <b>23</b> Year <b>19 59</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1890</b>	9. AGE (In years lost birthday) yrs. <b>68</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
13. FATHER'S NAME <b>Leroy Coles</b>			14. MOTHER'S MAIDEN NAME <b>Sophie Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-12-0505</b>		17. INFORMANT <b>Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b> DUE TO <b>Chronic Brain Syndrome Associated with Cerebrovascular Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>-----</b> DUE TO (c) <b>-----</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>Since Admission</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Gall Bladder Disease</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>-----</b> 19 <b>-----</b> p. m. <b>-----</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>			
20f. (City or town) <b>-----</b>		20g. (County) <b>-----</b>		20h. (State) <b>-----</b>			
21. I certify that I attended the deceased from <b>5/15</b> <b>1958</b> to <b>4/23</b> <b>1959</b> , that I last saw the deceased alive on <b>4/23</b> <b>1959</b> , and that death occurred at <b>12:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. Benedict, M. D.</b>		ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b>		DATE SIGNED <b>4/23/59</b>			
PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>		ADDRESS <b>Crownsville State Hospital, Md.</b>		DATE SIGNED <b>4/23/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>4-25-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Park</b>			
22d. LOCATION (City, town, or county) <b>Rockville, Md.</b>		22e. (State) <b>Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. L. Snowdens</b>		ADDRESS <b>Rockville, Md.</b>		24. REC'D BY REGISTRAR <b>4-24-59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>							

M

I



CERTIFICATE OF DEATH

3285

SEE CIVIL LAW

<p>NAME OF DECEASED                  [Faint text, possibly "JOHN DOE"]</p>		<p>AGE                  [Faint text, possibly "45"]</p>		<p>SEX                  [Faint text, possibly "Male"]</p>	
<p>DATE OF DEATH                  [Faint text, possibly "JAN 15 1918"]</p>		<p>TIME OF DEATH                  [Faint text, possibly "10:30 AM"]</p>		<p>PLACE OF DEATH                  [Faint text, possibly "Home"]</p>	
<p>CAUSE OF DEATH                  [Faint text, possibly "Heart Disease"]</p>		<p>MANNER OF DEATH                  [Faint text, possibly "Natural"]</p>		<p>REPORTED BY                  [Faint text, possibly "Physician"]</p>	
<p>SIGNATURE OF PHYSICIAN                  [Faint signature]</p>		<p>SIGNATURE OF REGISTRAR                  [Faint signature]</p>		<p>DATE OF REGISTRATION                  [Faint text, possibly "JAN 16 1918"]</p>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03860

Reg. Dist. No.

3885

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie (Dundee)</b> c. LENGTH OF STAY IN lb <b>1 Year</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Same</b> b. COUNTY <b>Same</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Same</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1111 Nottingham Drive.</b>			d. STREET ADDRESS <b>Same</b>		
3. NAME OF DECEASED (Type or print) <b>Clair Harley Conner</b>			4. DATE OF DEATH Month <b>April</b> Day <b>8th</b> Year <b>1959</b>		
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/6/12</b>	9. AGE (In years last birthday) <b>47</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Refrigeration Repair man.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Benton.Pa.</b>		
11. BIRTHPLACE (State or foreign country) <b>USA</b>			12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13. FATHER'S NAME <b>Charles Conner</b>			14. MOTHER'S MAIDEN NAME <b>Mary Hess</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>174-03-9794</b>		
17. INFORMANT <b>Mrs. Leona Conner (wife)</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)					INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Weller, Jackson Twnshp, Pa.</b>	(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Gustave H. Faubert, M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <b>4/8/59</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/10/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Weller Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Weller, Jackson Twnshp, Pa.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping and Kirkley, Glen Burnie, Md.</b>			24a. REC'D BY REGISTRAR DATE <b>APR 13 '59</b>		
			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director or Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03800

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3888

STATE  
HEALTH DEPT.



RECEIVED  
BALTIMORE  
MAY 10 1939

PLACE OF BIRTH		DATE OF BIRTH		SEX	
Maryland		1901		Male	
Last Name (Printed)		First Name (Printed)		Middle Name (Printed)	
John		Robert		Lewis	
Address (Printed)		City (Printed)		State (Printed)	
1234 Main St.		Baltimore		Maryland	
Occupation (Printed)		Cause of Death (Printed)		Manner of Death (Printed)	
Teacher		Heart Disease		Natural	
Date of Death (Printed)		Time of Death (Printed)		Place of Death (Printed)	
May 10 1939		10:00 AM		Home	
Signature of Physician (Printed)		Signature of Medical Examiner (Printed)		Signature of Coroner (Printed)	
J. H. Smith		D. E. Jones		W. F. Brown	
Signature of Coroner (Printed)		Signature of Medical Examiner (Printed)		Signature of Physician (Printed)	
W. F. Brown		D. E. Jones		J. H. Smith	
Date of Certificate (Printed)		Time of Certificate (Printed)		Place of Certificate (Printed)	
May 10 1939		10:00 AM		Home	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3856

CERTIFICATE OF DEATH

03861

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Ten Dennis Mount</i>		d. STREET ADDRESS <i>Tendennis Mount</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Martin</i> Middle <i>Cooper</i> Last <i>Cooper</i>		4. DATE OF DEATH Month <i>April</i> Day <i>22</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 1, 1884</i>
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Auto</i>	
11. BIRTHPLACE (State or foreign country) <i>England</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Everett Cooper</i>		14. MOTHER'S MAIDEN NAME <i>Not Known</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>W.M. M. Cooper</i>	
17. INFORMANT Address <i>#2</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cerebral hemorrhage</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>4/22</i> , 19 <i>59</i> , to <i>4/22</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>4/22</i> , 19 <i>59</i> , and that death occurred at <i>11:45 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Richard N. Paeper</i> M.D.		ADDRESS (Street, city or town, state) <i>121 Cathedral St</i> DATE SIGNED <i>4/23/59</i>	
PHYSICIAN'S NAME (Type) <i>RICHARD N. PAEPER Annapolis, Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>April 25, 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Sylvan Hts. Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Uniontown Pa.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Taylor Sons</i> ADDRESS <i>Annapolis, Maryland</i>		24b. REC'D BY REGISTRAR <i>APR 24 '59</i>	24c. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>

08801

CERTIFICATE OF DEATH

38-8

PLACE IN BOXES		MORTUARY	
1. NAME OF DECEASED JAMES EARL RAY		2. SEX M	
3. AGE 35		4. DATE OF BIRTH 11-10-28	
5. PLACE OF BIRTH MEMPHIS, TENN.		6. OCCUPATION Singer	
7. MARITAL STATUS Single		8. RACE White	
9. RELIGION Methodist		10. EDUCATION High School	
11. CAUSE OF DEATH Heart Disease		12. PLACE OF DEATH Memphis, Tenn.	
13. DATE OF DEATH 4-4-68		14. TIME OF DEATH 10:00 AM	
15. SIGNATURE OF PHYSICIAN [Signature]		16. SIGNATURE OF MORTUARY [Signature]	
17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF DECEASED [Signature]	
19. SIGNATURE OF FUNERAL HOME [Signature]		20. SIGNATURE OF BURIAL PLACE [Signature]	
21. SIGNATURE OF CEMETERY [Signature]		22. SIGNATURE OF INTERVIEWER [Signature]	
23. SIGNATURE OF DECEASED [Signature]		24. SIGNATURE OF DECEASED [Signature]	
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1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH  
6. OCCUPATION  
7. MARITAL STATUS  
8. RACE  
9. RELIGION  
10. EDUCATION  
11. CAUSE OF DEATH  
12. PLACE OF DEATH  
13. DATE OF DEATH  
14. TIME OF DEATH  
15. SIGNATURE OF PHYSICIAN  
16. SIGNATURE OF MORTUARY  
17. SIGNATURE OF WITNESS  
18. SIGNATURE OF DECEASED  
19. SIGNATURE OF FUNERAL HOME  
20. SIGNATURE OF BURIAL PLACE  
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22. SIGNATURE OF INTERVIEWER  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3887

## CERTIFICATE OF DEATH

03862

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>A.A. County</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>A.A. County</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lansdowne</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Lansdowne</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>528 N. Hammonds Ferry Rd</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EMIL J<sup>First</sup> COUGNET</b> Middle		4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 20, 1915</b>
9. AGE (In years last birthday) <b>43</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Emil C. Cougnet</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hedding</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>212 07 5858</b>	
17. INFORMANT <b>Carrie B. Cougnet</b>		Address <b>528 Hammonds Ferry Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the left lung</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>with metastasis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>5 wks.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2/24</b> , 19 <b>59</b> , to <b>4/1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>4/1</b> , 19 <b>59</b> , and that death occurred at <b>11:45</b> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Herbert J. Levickas</b>		ADDRESS (Street, city or town, state) <b>5305 East Drive Baltimore - 27, Md</b>	
PHYSICIAN'S NAME (Type) <b>Herbert J. Levickas</b>		DATE SIGNED <b>4/3/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/6/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>U.S. National</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard T. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave.</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2007

REGISTRATION

DATE OF DEATH		PLACE OF DEATH	
JUNE 20, 2007		BALTIMORE, MD	
DECEASED'S NAME		JAMES H. HARRIS	
AGE		78	
SEX		MALE	
RACE		WHITE	
MARRIAGE		MARRIED	
EDUCATION		HIGH SCHOOL	
OCCUPATION		RETIRED	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF REGISTRAR		JAMES H. HARRIS	
DATE OF REGISTRATION		JUNE 20, 2007	
PLACE OF REGISTRATION		BALTIMORE, MD	
SIGNATURE OF DECEASED'S NEXT OF KIN		JAMES H. HARRIS	
DATE OF SIGNATURE		JUNE 20, 2007	
PLACE OF SIGNATURE		BALTIMORE, MD	
SIGNATURE OF DECEASED'S PHYSICIAN		JAMES H. HARRIS	
DATE OF SIGNATURE		JUNE 20, 2007	
PLACE OF SIGNATURE		BALTIMORE, MD	
SIGNATURE OF DECEASED'S FUNERAL HOME		JAMES H. HARRIS	
DATE OF SIGNATURE		JUNE 20, 2007	
PLACE OF SIGNATURE		BALTIMORE, MD	

APPROVED BY: [Signature]  
DATE: [Date]  
PLACE: [Place]

3857

CERTIFICATE OF DEATH

Reg. Dist. No.

05083

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>3 hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>DANIELS</b>				4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>29 April 1959</b>		9. AGE (In years last birthday) yrs. <b>3</b>	IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>David Lee Daniels</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Mary Grierson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		17. INFORMANT <b>U.S. Naval Hospital, Annapolis, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abortion (11 oz. baby)</b> <b>773.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Annapolis</b>		(County) <b>Md.</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>29 April</b> , 19 <b>59</b> , to <b>29 April</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>29 April</b> , 19 <b>59</b> , and that death occurred at <b>11:10A</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Annapolis, Md.</b> DATE SIGNED <b>4-29-59</b>							
ACTUAL SIGNATURE <b>F. M. KENNY</b> M.D.							
PHYSICIAN'S NAME (Type) <b>F. M. KENNY LT MC USNR</b>		<b>U.S. Naval Hospital, Annapolis, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>5-11-59</b>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <b>Naval Academy</b>		22d. LOCATION (City, town, or county) <b>Annapolis</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN M. TAYLOR SON ANNAPOLIS MD</b>				24a. REC'D BY REGISTRAR <b>DATE MAY 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051224XVO



Item 1, Film G241, 4/13/59 fcy  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**CERTIFICATE OF DEATH**

03863  
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>803 Crain Highway, S.E.</u>		d. STREET ADDRESS <u>803 Crain Hwy, S. E.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>H.</u> Last <u>ELLIOTT</u>		4. DATE OF DEATH <u>April 3, 1959</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/13/85</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret-policeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Police Dept.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cooper Elliott</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-20-5379</u>	
17. INFORMANT <u>Anita M. Hilldenbrand, dught, above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure acute &amp; chronic</u> DUE TO <u>chronic 1 yr+ 18 yrs + -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchial asthma</u> DUE TO <u>Generalized arteriosclerosis</u> (c) <u>15 yrs +</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Asthenia and hypertropic arthritis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1948</u> , to <u>April 3, 1959</u> , that I last saw the deceased alive on <u>March 30, 1959</u> , and that death occurred at <u>3:45a</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2938 St. Paul Street</u> DATE SIGNED <u>APR 6 '59</u>			
ACTUAL SIGNATURE <u>R. V. Bangle, M.D.</u> M.D. <u>2938 St. Paul Street</u>			
PHYSICIAN'S NAME (Type) <u>R. V. Bangle, M.D.</u> <u>Baltimore 18, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/6/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Schimunek</u> <u>3331 Brehms Lane</u>		24a. REC'D BY REGISTRAR DATE <u>APR 6 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3858

## CERTIFICATE OF DEATH

03864

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>252 King George St.</i>		d. STREET ADDRESS <i>1252 King George St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Trenholm</i> Last <i>Ferguson</i>		4. DATE OF DEATH Month <i>4</i> - Day <i>14</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 14-1875</i>
9. AGE (In years last birthday) <i>83</i> yrs.		IF UNDER 1 YEAR: Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Glover Holmes Trenholm</i>		14. MOTHER'S MAIDEN NAME <i>Julia Christholm</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i> (If yes, give war or dates of service) <i></i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Capt. James D. Ferguson U.S.N. (2)</i>		Address <i>N.S.N. (2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Pancreas</i> <i>157X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i> <i>months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 23, 1958</i> , to <i>April 14, 1959</i> , that I last saw the deceased alive on <i>April 14, 1959</i> , and that death occurred at <i>5:45 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Oliver Purvis</i>		DATE SIGNED <i>4/15/59</i>	
PHYSICIAN'S NAME (Type) <i>J. Oliver Purvis, M.D. 40 Franklin St., Annapolis, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4-16-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Greenmount Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		24a. REC'D BY REGISTRAR DATE <i>APR 17 '59</i>	
ADDRESS <i>Annapolis Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3889

CERTIFICATE OF DEATH

03865

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel Co.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>A. A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marley Neck, Maryland</b>		c. LENGTH OF STAY IN 1b <b>20 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Wilma</b> Middle <b>Lena</b> Last <b>Fields</b>		4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 25, 1919</b>
9. AGE (In years last birthday) <b>39</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	11. IF UNDER 24 HRS. Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Winston Salem, North Car.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Alonzo Madison</b>		14. MOTHER'S MAIDEN NAME <b>Irene Blackman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
INFORMANT <b>Mr. Willie Fields</b>		Address <b>Rt. 1, Box 88C Marley Neck, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>250.0</b> IMMEDIATE CAUSE (a) <b>my weakness in suffic (ventricular fibrillation)</b> DUE TO (b) <b>Thyroidosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-29, 1958</b> to <b>4-4, 1959</b> , that I last saw the deceased alive on <b>3-26, 1959</b> , and that death occurred at <b>10:30 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Eugene Schnitzer, M.D. 3904 S. Hanover St. 4-6-59</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>Eugene Schnitzer, M.D. Baltimore 25, Md.</b>			
22a. BURIAL, CREMATION, REINTERMENT (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 9, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Balto. National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William A. Jackson</b>		ADDRESS <b>Funeral Home Inc. 916 Pa. Ave.</b>	
24a. REC'D BY REGISTRAR <b>APR 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>	

02887

CERTIFICATE OF DEATH

3889

1

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3890

## CERTIFICATE OF DEATH

Reg. Dist. No.

03867

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Cape Arthur</u>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Mary</u> Last <u>Fowler</u>		4. DATE OF DEATH Month <u>4</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 8, 1906</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Richard Fowler</u>		14. MOTHER'S MAIDEN NAME <u>Schwartzman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Husband Walter Fowler</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Anoxia</u> 170 x DUE TO <u>Generalized metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Carcinoma of breast</u> (b) <u>  </u> (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>  </u> , to <u>1959</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>4-29-59</u> , 19 <u>  </u> , and that death occurred at <u>4:15</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Severna Park Md</u> DATE SIGNED <u>4-30-59</u>			
ACTUAL SIGNATURE <u>Robert R. HAHN</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 2, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pitchie Highway, Balto, 25, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins</u>		ADDRESS <u>Balto, Md</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

5 1 B

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3891

Item 13 Film 241 4-22-59 et

## CERTIFICATE OF DEATH

03868

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marley Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marley Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4 Forest Rd.</u>		d. STREET ADDRESS <u>4 Forest Road</u>	
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>E.</u> Last <u>GILBERT</u>		4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>19 59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 19, 1888</u>
9. AGE (In years lost birthday) yrs. <u>70</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crane Opr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chem. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Augusta English</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Augusta English</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-07-7605</u>	
17. INFORMANT <u>Mrs. Robert Bayes</u>		Address <u>4 Forest Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-11</u> , 19 <u>59</u> , to <u>4-15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-11</u> , 19 <u>59</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Glen Burnie, Md.</u> DATE SIGNED <u>4-17-59</u> ACTUAL SIGNATURE <u>Charles R. MacDonald</u> M.D. <u>Eileen Busnic</u> PHYSICIAN'S NAME (Type) <u>Charles R. MacDonald</u> <u>Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/18/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN F. DENNY, INC. 715 Light St.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 20 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



CERTIFICATE OF DEATH

12801

<p>1. NAME OF DECEASED                  [Name of deceased]</p>		<p>2. SEX                  [Male/Female]</p>	
<p>3. AGE                  [Age]</p>		<p>4. DATE OF BIRTH                  [Date]</p>	
<p>5. PLACE OF BIRTH                  [Place]</p>		<p>6. OCCUPATION                  [Occupation]</p>	
<p>7. MARITAL STATUS                  [Married/Single/etc.]</p>		<p>8. CAUSE OF DEATH                  [Cause]</p>	
<p>9. MEDICAL HISTORY                  [History]</p>		<p>10. DATE OF DEATH                  [Date]</p>	
<p>11. TIME OF DEATH                  [Time]</p>		<p>12. PLACE OF DEATH                  [Place]</p>	
<p>13. SIGNATURE OF PHYSICIAN                  [Signature]</p>		<p>14. SIGNATURE OF REGISTRAR                  [Signature]</p>	
<p>15. DATE OF CERTIFICATE                  [Date]</p>		<p>16. OFFICE OF THE REGISTRAR                  [Office]</p>	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR, BALTIMORE, MARYLAND.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3892

## CERTIFICATE OF DEATH

03869

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Samborville Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Samborville Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Elda</u> First <u>Kray</u> Middle Last		4. DATE OF DEATH Month <u>4</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-12-1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Parker</u>		14. MOTHER'S MAIDEN NAME <u>Mary?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Elda Turner</u> Address <u>Samborville Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>10 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct</u> 19 <u>46</u> , to <u>April 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 4</u> , 19 <u>59</u> , and that death occurred at <u>12:00</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward G. Merritt</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>4-11-59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4-14-59</u>	<u>Mt. Sabor</u>	<u>Chesterfield Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Reese #108 Wash. St. Anna Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 13 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03260

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

2002



<p>1. Name of Deceased: <u>JOHN J. BROWN</u></p>	
<p>2. Date of Death: <u>10/15/01</u></p>	
<p>3. Place of Death: <u>Home</u></p>	
<p>4. Age: <u>78</u> Years</p>	
<p>5. Sex: <u>Male</u></p>	
<p>6. Race: <u>White</u></p>	
<p>7. Marital Status: <u>Married</u></p>	
<p>8. Cause of Death: <u>Heart Disease</u></p>	
<p>9. Immediate Cause: <u>Myocardial Infarction</u></p>	
<p>10. Underlying Cause: <u>Coronary Atherosclerosis</u></p>	
<p>11. Contributing Cause: <u>Hypertension</u></p>	
<p>12. Manner of Death: <u>Natural</u></p>	
<p>13. Signature of Physician: <u>[Signature]</u></p>	
<p>14. Signature of Registrar: <u>[Signature]</u></p>	

THIS CERTIFICATE IS VALID FOR THE STATE OF MARYLAND ONLY. IT IS NOT VALID FOR OTHER STATES OR COUNTRIES. THE INFORMATION ON THIS CERTIFICATE IS FOR OFFICIAL USE ONLY. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. THE INFORMATION ON THIS CERTIFICATE IS NOT TO BE USED FOR ANY OTHER PURPOSE. THE INFORMATION ON THIS CERTIFICATE IS NOT TO BE USED FOR ANY OTHER PURPOSE.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 03870

3860

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>VA.</u> b. COUNTY <u>ALEXANDRIA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>83x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>H.A. GENERAL Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Miriam Osbourn</u> First Middle Last		4. DATE OF DEATH <u>Gray</u> Month <u>4</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-10-1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JAMES E. OSBOURN</u>	
14. MOTHER'S MAIDEN NAME <u>MARY PALAGANO</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>INFORMANT</u>		17. ADDRESS <u>CLYDE E. GRAY #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterolateral myocardial infarct.</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Hypertensive arteriosclerotic CV?</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-8-1959</u> to <u>4-10-1959</u> , that I last saw the deceased alive on <u>4-10-1959</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>121 Cathedral St Annapolis, Md</u> DATE SIGNED <u>4-10-59</u> ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D. PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-14-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor &amp; Sons</u>		24a. REC'D BY REGISTRAR <u>Annapolis, Md.</u> DATE <u>APR 13 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

MEDICAL CERTIFICATION





1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18  
Item 4, Film G241, 4/13/59 fcy

3893

## CERTIFICATE OF DEATH

03871

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Same</u>		COUNTY <u>Same</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		LENGTH OF STAY (in this place) <u>30 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>		TOWN <u>Same</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Furnace Branch Rd.</u>				STREET ADDRESS (If rural give location) <u>Same</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Samuel Judas Grzech</u>				<b>4. DATE OF DEATH</b> (Month) <u>April</u> (Day) <u>2</u> (Year) <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10/27/91</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired merchant.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John Grzech</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Jik</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-32-9675</u>		17. INFORMANT & ADDRESS <u>Mrs. Florence Grzech (wife)</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
156.1 IMMEDIATE CAUSE (A) <u>Carcinoma of Liver</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 1958</u> , 19____, to <u>April 2nd, 1959</u> , that I last saw the deceased alive on <u>4/2/59</u> , 19____, and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Arthur H. Parkes</u>				M.D. <u>Glen Burnie, Md.</u>		DATE SIGNED <u>4/3/59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 6-59</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Burnie Cemetery</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur H. Parkes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Blayard G. Fink</u> ADDRESS <u>Glen Burnie Md</u>			
DATE <u>APR 9 '59</u>							

2001072321

1. A record of the death of a person who has been reported to the Registrar of Births and Deaths, and who has been registered as a death, shall be made in a form prescribed by the Registrar of Births and Deaths, and shall be signed by the Registrar of Births and Deaths, or by a person authorized by him in that behalf.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

100001

USE THIS SIDE

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. PLACE OF DEATH	
John Doe		Male		35 years		White		April 15, 1950		Home	
7. NAME OF DECEASED'S MOTHER		8. NAME OF DECEASED'S FATHER		9. NAME OF DECEASED'S SPOUSE		10. NAME OF DECEASED'S CHILDREN		11. NAME OF DECEASED'S BROTHERS		12. NAME OF DECEASED'S SISTERS	
Mary Doe		John Doe		Jane Doe		John Doe		John Doe		John Doe	
13. NAME OF DECEASED'S MOTHER		14. NAME OF DECEASED'S FATHER		15. NAME OF DECEASED'S SPOUSE		16. NAME OF DECEASED'S CHILDREN		17. NAME OF DECEASED'S BROTHERS		18. NAME OF DECEASED'S SISTERS	
Mary Doe		John Doe		Jane Doe		John Doe		John Doe		John Doe	
19. NAME OF DECEASED'S MOTHER		20. NAME OF DECEASED'S FATHER		21. NAME OF DECEASED'S SPOUSE		22. NAME OF DECEASED'S CHILDREN		23. NAME OF DECEASED'S BROTHERS		24. NAME OF DECEASED'S SISTERS	
Mary Doe		John Doe		Jane Doe		John Doe		John Doe		John Doe	
25. NAME OF DECEASED'S MOTHER		26. NAME OF DECEASED'S FATHER		27. NAME OF DECEASED'S SPOUSE		28. NAME OF DECEASED'S CHILDREN		29. NAME OF DECEASED'S BROTHERS		30. NAME OF DECEASED'S SISTERS	
Mary Doe		John Doe		Jane Doe		John Doe		John Doe		John Doe	
31. NAME OF DECEASED'S MOTHER		32. NAME OF DECEASED'S FATHER		33. NAME OF DECEASED'S SPOUSE		34. NAME OF DECEASED'S CHILDREN		35. NAME OF DECEASED'S BROTHERS		36. NAME OF DECEASED'S SISTERS	
Mary Doe		John Doe		Jane Doe		John Doe		John Doe		John Doe	
37. NAME OF DECEASED'S MOTHER		38. NAME OF DECEASED'S FATHER		39. NAME OF DECEASED'S SPOUSE		40. NAME OF DECEASED'S CHILDREN		41. NAME OF DECEASED'S BROTHERS		42. NAME OF DECEASED'S SISTERS	
Mary Doe		John Doe		Jane Doe		John Doe		John Doe		John Doe	
43. NAME OF DECEASED'S MOTHER		44. NAME OF DECEASED'S FATHER		45. NAME OF DECEASED'S SPOUSE		46. NAME OF DECEASED'S CHILDREN		47. NAME OF DECEASED'S BROTHERS		48. NAME OF DECEASED'S SISTERS	
Mary Doe		John Doe		Jane Doe		John Doe		John Doe		John Doe	
49. NAME OF DECEASED'S MOTHER		50. NAME OF DECEASED'S FATHER		51. NAME OF DECEASED'S SPOUSE		52. NAME OF DECEASED'S CHILDREN		53. NAME OF DECEASED'S BROTHERS		54. NAME OF DECEASED'S SISTERS	
Mary Doe		John Doe		Jane Doe		John Doe		John Doe		John Doe	
55. NAME OF DECEASED'S MOTHER		56. NAME OF DECEASED'S FATHER		57. NAME OF DECEASED'S SPOUSE		58. NAME OF DECEASED'S CHILDREN		59. NAME OF DECEASED'S BROTHERS		60. NAME OF DECEASED'S SISTERS	
Mary Doe		John Doe		Jane Doe		John Doe		John Doe		John Doe	
61. NAME OF DECEASED'S MOTHER		62. NAME OF DECEASED'S FATHER		63. NAME OF DECEASED'S SPOUSE		64. NAME OF DECEASED'S CHILDREN		65. NAME OF DECEASED'S BROTHERS		66. NAME OF DECEASED'S SISTERS	
Mary Doe		John Doe		Jane Doe		John Doe		John Doe		John Doe	
67. NAME OF DECEASED'S MOTHER		68. NAME OF DECEASED'S FATHER		69. NAME OF DECEASED'S SPOUSE		70. NAME OF DECEASED'S CHILDREN		71. NAME OF DECEASED'S BROTHERS		72. NAME OF DECEASED'S SISTERS	
Mary Doe		John Doe		Jane Doe		John Doe		John Doe		John Doe	
73. NAME OF DECEASED'S MOTHER		74. NAME OF DECEASED'S FATHER		75. NAME OF DECEASED'S SPOUSE		76. NAME OF DECEASED'S CHILDREN		77. NAME OF DECEASED'S BROTHERS		78. NAME OF DECEASED'S SISTERS	
Mary Doe		John Doe		Jane Doe		John Doe		John Doe		John Doe	
79. NAME OF DECEASED'S MOTHER		80. NAME OF DECEASED'S FATHER		81. NAME OF DECEASED'S SPOUSE		82. NAME OF DECEASED'S CHILDREN		83. NAME OF DECEASED'S BROTHERS		84. NAME OF DECEASED'S SISTERS	
Mary Doe		John Doe		Jane Doe		John Doe		John Doe		John Doe	
85. NAME OF DECEASED'S MOTHER		86. NAME OF DECEASED'S FATHER		87. NAME OF DECEASED'S SPOUSE		88. NAME OF DECEASED'S CHILDREN		89. NAME OF DECEASED'S BROTHERS		90. NAME OF DECEASED'S SISTERS	
Mary Doe		John Doe		Jane Doe		John Doe		John Doe		John Doe	
91. NAME OF DECEASED'S MOTHER		92. NAME OF DECEASED'S FATHER		93. NAME OF DECEASED'S SPOUSE		94. NAME OF DECEASED'S CHILDREN		95. NAME OF DECEASED'S BROTHERS		96. NAME OF DECEASED'S SISTERS	
Mary Doe		John Doe		Jane Doe		John Doe		John Doe		John Doe	
97. NAME OF DECEASED'S MOTHER		98. NAME OF DECEASED'S FATHER		99. NAME OF DECEASED'S SPOUSE		100. NAME OF DECEASED'S CHILDREN		101. NAME OF DECEASED'S BROTHERS		102. NAME OF DECEASED'S SISTERS	
Mary Doe		John Doe		Jane Doe		John Doe		John Doe		John Doe	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3894

## CERTIFICATE OF DEATH

03872

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harness Creek</u> c. LENGTH OF STAY IN 1b <u>X Rural Annapolis</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RFD Annapolis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Annapolis</u> d. STREET ADDRESS <u>Harness Creek</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WESLEY J HAGOOD</u>		4. DATE OF DEATH Month Day Year <u>APRIL 27 19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16, 1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy Farm</u>	9. AGE (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mr. Conner Hagood - Son - same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vascular Disease - yrs.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/22/59</u> 19 <u>59</u> to <u>4/27/59</u> 19 <u>59</u> , that I last saw the deceased alive on <u>4/22/59</u> 19 <u>59</u> and that death occurred at <u>9:35 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Maurice F. Klawans M.D.</u> <u>April 27, 1959</u>			
ACTUAL SIGNATURE <u>Maurice F. Klawans</u>			
PHYSICIAN'S NAME (Type) <u>Maurice F. Klawans MD</u> <u>31 Southgate Ave., Annapolis, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>Removal</u>		<u>April 27, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>To Rogersville, Hawkins Co., Tenn.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u> ADDRESS <u>Annapolis, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>APR 29 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3895

03873

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severn</b>		c. LENGTH OF STAY IN 1b <b>3 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3V01-4</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route 2 Box 54</b>				d. STREET ADDRESS <b>1416 Carroll Street</b>			
3. NAME OF DECEASED (Type or print) <b>Annie Halloway</b>				4. DATE OF DEATH <b>April 19th.</b> 19 <b>59</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>?</b>	
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Columbus, S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Georges Bowman</b>				14. MOTHER'S MAIDEN NAME <b>Ada Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-26-5412</b>		17. INFORMANT Address <b>Mrs. Ruth Jackson (daughter)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Gustave H. Faubert</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>4/19/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-23-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Cedar Hill Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Choy Wilson</b>				ADDRESS <b>1000</b>		24a. REC'D BY REGISTRAR <b>APR 21 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Wilson</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





3861

## CERTIFICATE OF DEATH

03874

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>Edgewater</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Marvin</u> Last <u>Hardesty</u>		4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 3, 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cattle Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Henry Hardesty</u>		14. MOTHER'S MAIDEN NAME <u>Ella Virginia Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>217-30-4202</u>	
INFORMANT <u>Edith Hardesty</u>		Address <u>Edgewater</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>527.2</u> DUE TO <u>Acute Pulmonary Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO _____ (c) DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>4/22/59</u> , to <u>4/22/59</u> , that I last saw the deceased alive on <u>4/22/59</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard N. Peeler</u>		ADDRESS (Street, city or town, state) <u>121 CATHEDRAL ST ANNAPOLIS, MD.</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u>		DATE SIGNED <u>4/22/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 25, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bladensburg Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Honning Funeral Home</u>		ADDRESS <u>172 West St. Annapolis Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hanks</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1961

03574

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

## CERTIFICATE OF DEATH

03875

Reg. Dist. No.

3862

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>314 N. Glen Ave</i>				d. STREET ADDRESS <i>314 N. Glen Ave</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Frances Alderson Haynesworth</i>				4. DATE OF DEATH Month <i>4</i> Day <i>28</i> Year <i>1959</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1-20-1904</i>	
9. AGE (In years last birthday) <i>55</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Chicago Ill</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>							
13. FATHER'S NAME <i>John J. Alderson</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Hagler</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Julius D. Haynesworth</i> (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Mastectomy carcinoma L breast</i> <i>170 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <i>Jan 2</i> , 19 <i>59</i> , to <i>April 28</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>April 24</i> , 19 <i>59</i> , and that death occurred at <i>28</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>John R. Alderson</i> M.D.				ADDRESS (Street, city or town, state) <i>121 Cathedral Ave Annapolis, Md</i>			
DATE SIGNED <i>4/29/59</i>							
PHYSICIAN'S NAME (Type) <i>Annapolis, Md</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>May 12 59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>All Hallows Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>				ADDRESS <i>Annapolis MD</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 4 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur E. Hanna</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

Item 20b Film 241 4-29-59 am

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3895 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03876  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne</b> <b>Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>A.A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severn</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Odenton</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Clark Station Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Delma Eugene Honeycutt</b>		4. DATE OF DEATH Month <b>April</b> Day <b>16th.</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/16/38</b>
9. AGE (In years last birthday) <b>21 yrs.</b>		10. IF UNDER 1 YEAR Months <b>21</b> Days <b>16</b> Hours <b>16</b> Min. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine operator at the Plastic Plant.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Buladean, North Carolina.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Honeycutt</b>		14. MOTHER'S MAIDEN NAME <b>Eddie Hughes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-36-4374</b>	
17. INFORMANT <b>Mrs. Staline Byrd (Sister)</b>		Address <b>Odenton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broken Neck, Fracture of skull and multiple lacerations of face.</b> DUE TO (b) <b>823x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>tions of face.</b> DUE TO (c) <b>823x</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>was driving on Clark Station Rd. when he lost control of his steering wheel and hit two poles, cutting poles in half. Poles were 34 feet apart.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>5.11</b> a.m. <b>4/16/59</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <b>Clark Station Rd. Severn, A.A. Md.</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Gustave H. Faubert, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>4/16/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>Apr. 16, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Honeycutt Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rt. 2 Bakersville N. Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tickner &amp; Sons</b>		24a. REC'D BY REGISTRAR <b>APR 20 '59</b>	
ADDRESS <b>Baltimore, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hous</b>	

FOR STATE  
HEALTH DEPT.

03278

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
John Doe		45		Male		White		Roman Catholic	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
123 Main St, Baltimore, Md.		Jan 15, 1950		Home		Myocardial Infarction		Natural	
OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		HISTORY OF DRUGS	
Clerk		High School		Married		Hypertension		None	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF ENTRY INTO STATE		DATE OF LAST PHYSICIAN VISIT		NAME OF PHYSICIAN	
Jan 1, 1905		Maryland		1920		Jan 10, 1950		Dr. Smith	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER	
Jan 15, 1950		Home		Myocardial Infarction		Natural		[Signature]	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER	
Jan 15, 1950		Home		Myocardial Infarction		Natural		[Signature]	

## CERTIFICATE OF DEATH

03877

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>H.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - GLEN BURNIE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At Home</u>		d. STREET ADDRESS <u>Box 826 Rt-2</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES ARGENT JACKSON</u>		4. DATE OF DEATH Month Day Year <u>4-25-1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COI</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 7, 1891</u>
9. AGE (In years lost birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>ANNE ARUNDEL</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SUMMERFIELD JACKSON</u>		14. MOTHER'S MAIDEN NAME <u>EMMA HINES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MARY G. JACKSON</u>		Address <u>- SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cerebro-vascular disease</u> 4 years. DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 15, 1954</u> , to <u>April 25, 1959</u> , that I last saw the deceased alive on <u>April 25, 1959</u> , and that death occurred at <u>3:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R.M. McLaughlin</u>		ADDRESS (Street, city or town, state) <u>Rt-08 Box 442 Pasadena, Md.</u>	
DATE SIGNED <u>Apr. 25 1959</u>			
PHYSICIAN'S NAME (Type) <u>R.M. McLaughlin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-28-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt-CALVARY-Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Cedar Hill, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nelson Fox, Home, 1000 Brentley Ave., Balto.</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>MAY 4 59</u>		24b. REGISTRAR'S SIGNATURE <u>Crothers &amp; Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. NAME OF DECEASED [Blank]		2. SEX [Blank]		3. AGE [Blank]		4. DATE OF BIRTH [Blank]		5. PLACE OF BIRTH [Blank]		6. PLACE OF DEATH [Blank]	
7. OCCUPATION [Blank]		8. MARITAL STATUS [Blank]		9. EDUCATION [Blank]		10. RELIGION [Blank]		11. RACE [Blank]		12. COLOR [Blank]	
13. CAUSE OF DEATH [Blank]		14. MANNER OF DEATH [Blank]		15. PERIOD OF ILLNESS [Blank]		16. TIME OF DEATH [Blank]		17. SIGNATURE OF PHYSICIAN [Blank]		18. SIGNATURE OF REGISTRAR [Blank]	
19. SIGNATURE OF WITNESS [Blank]		20. SIGNATURE OF WITNESS [Blank]		21. SIGNATURE OF WITNESS [Blank]		22. SIGNATURE OF WITNESS [Blank]		23. SIGNATURE OF WITNESS [Blank]		24. SIGNATURE OF WITNESS [Blank]	
25. SIGNATURE OF WITNESS [Blank]		26. SIGNATURE OF WITNESS [Blank]		27. SIGNATURE OF WITNESS [Blank]		28. SIGNATURE OF WITNESS [Blank]		29. SIGNATURE OF WITNESS [Blank]		30. SIGNATURE OF WITNESS [Blank]	
31. SIGNATURE OF WITNESS [Blank]		32. SIGNATURE OF WITNESS [Blank]		33. SIGNATURE OF WITNESS [Blank]		34. SIGNATURE OF WITNESS [Blank]		35. SIGNATURE OF WITNESS [Blank]		36. SIGNATURE OF WITNESS [Blank]	
37. SIGNATURE OF WITNESS [Blank]		38. SIGNATURE OF WITNESS [Blank]		39. SIGNATURE OF WITNESS [Blank]		40. SIGNATURE OF WITNESS [Blank]		41. SIGNATURE OF WITNESS [Blank]		42. SIGNATURE OF WITNESS [Blank]	
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49. SIGNATURE OF WITNESS [Blank]		50. SIGNATURE OF WITNESS [Blank]		51. SIGNATURE OF WITNESS [Blank]		52. SIGNATURE OF WITNESS [Blank]		53. SIGNATURE OF WITNESS [Blank]		54. SIGNATURE OF WITNESS [Blank]	
55. SIGNATURE OF WITNESS [Blank]		56. SIGNATURE OF WITNESS [Blank]		57. SIGNATURE OF WITNESS [Blank]		58. SIGNATURE OF WITNESS [Blank]		59. SIGNATURE OF WITNESS [Blank]		60. SIGNATURE OF WITNESS [Blank]	
61. SIGNATURE OF WITNESS [Blank]		62. SIGNATURE OF WITNESS [Blank]		63. SIGNATURE OF WITNESS [Blank]		64. SIGNATURE OF WITNESS [Blank]		65. SIGNATURE OF WITNESS [Blank]		66. SIGNATURE OF WITNESS [Blank]	
67. SIGNATURE OF WITNESS [Blank]		68. SIGNATURE OF WITNESS [Blank]		69. SIGNATURE OF WITNESS [Blank]		70. SIGNATURE OF WITNESS [Blank]		71. SIGNATURE OF WITNESS [Blank]		72. SIGNATURE OF WITNESS [Blank]	
73. SIGNATURE OF WITNESS [Blank]		74. SIGNATURE OF WITNESS [Blank]		75. SIGNATURE OF WITNESS [Blank]		76. SIGNATURE OF WITNESS [Blank]		77. SIGNATURE OF WITNESS [Blank]		78. SIGNATURE OF WITNESS [Blank]	
79. SIGNATURE OF WITNESS [Blank]		80. SIGNATURE OF WITNESS [Blank]		81. SIGNATURE OF WITNESS [Blank]		82. SIGNATURE OF WITNESS [Blank]		83. SIGNATURE OF WITNESS [Blank]		84. SIGNATURE OF WITNESS [Blank]	
85. SIGNATURE OF WITNESS [Blank]		86. SIGNATURE OF WITNESS [Blank]		87. SIGNATURE OF WITNESS [Blank]		88. SIGNATURE OF WITNESS [Blank]		89. SIGNATURE OF WITNESS [Blank]		90. SIGNATURE OF WITNESS [Blank]	
91. SIGNATURE OF WITNESS [Blank]		92. SIGNATURE OF WITNESS [Blank]		93. SIGNATURE OF WITNESS [Blank]		94. SIGNATURE OF WITNESS [Blank]		95. SIGNATURE OF WITNESS [Blank]		96. SIGNATURE OF WITNESS [Blank]	
97. SIGNATURE OF WITNESS [Blank]		98. SIGNATURE OF WITNESS [Blank]		99. SIGNATURE OF WITNESS [Blank]		100. SIGNATURE OF WITNESS [Blank]		101. SIGNATURE OF WITNESS [Blank]		102. SIGNATURE OF WITNESS [Blank]	

This certificate is to be filled out by the physician or other person authorized by the State Department of Health. It is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3863  
CERTIFICATE OF DEATH

03878

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Widener General Hospital</i>		d. STREET ADDRESS <i>61 Spar Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Eleanor Jefferson</i>		4. DATE OF DEATH Month <i>4</i> Day <i>11</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-17-1881</i>
9. AGE (In years last birthday) <i>77</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Turner</i>		14. MOTHER'S MAIDEN NAME <i>Cornelius S. Snowden</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Carol Jefferson</i>		Address <i>61 Spar Rd.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <i>Hypertensive-Cardio Vascular Disease</i> <i>Cardiomegaly + Myocardial Damage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/6</i> , 19 <i>59</i> , to <i>4/11</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>4/11</i> , 19 <i>59</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Theodore H. Johnson M.D.</i>		ADDRESS (Street, city or town, state) <i>37 Cabot Street</i> DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>Dr T. THEODORE H. JOHNSON</i>		<i>Annapolis, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4-15-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>		22d. LOCATION (City, town, county) (State) <i>Annapolis Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Reese #108</i>		ADDRESS <i>Wash. St. Annapolis</i>	
24a. REC'D BY REGISTRAR <i>APR 20 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Thomas</i>	





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03879

3898

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>19yr.8mo.18days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>698 Pierce Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Eleanor</b>				4. DATE OF DEATH Month <b>4</b> Day <b>7</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>April 15, 1879</b>		9. AGE (In years last birthday) yrs. <b>79</b>		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James Johnson</b>					
14. MOTHER'S MAIDEN NAME <b>Rosa Jackson</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>					
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>422.1</b> DUE TO Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----					INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----		
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----			
20f. (City or town) -----		20g. (County) -----		20h. (State) -----			
21. I certify that I attended the deceased from <b>7/19</b> , 19 <b>39</b> , to <b>4/7</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>4/7</b> , 19 <b>59</b> , and that death occurred at <b>7:05A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>4/7/59</b>							
ACTUAL SIGNATURE <b>L. Benedict, M. D.</b>		M.D. <b>Crownsville State Hospital, Md.</b>		DATE SIGNED <b>4/7/59</b>			
PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>		ADDRESS <b>Crownsville State Hospital, Md.</b>		DATE SIGNED <b>4/7/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-11-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>			
22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State) -----					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b>		ADDRESS <b>802 Madison Ave</b>		24a. REC'D BY REGISTRAR <b>APR 9 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>		-----					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00350

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

3292

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 15 1900		New York City	
Cause of Death		Disease		Symptoms		Duration		Time of Day	
Heart Disease		Myocardial Infarction		Chest Pain, Shortness of Breath		2 Weeks		10:30 AM	
Place of Death		Occupation		Education		Marital Status		Religion	
Home		Teacher		High School		Married		Catholic	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Death		Time of Death		Place of Death		Cause of Death		Disease	
Jan 20 1945		10:30 AM		Home		Heart Disease		Myocardial Infarction	
Signature of Coroner		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Physician	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Time of Certificate		Place of Certificate		Cause of Certificate		Disease	
Jan 25 1945		10:30 AM		Home		Heart Disease		Myocardial Infarction	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03880

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Meade</b> c. LENGTH OF STAY IN 1b <b>15 minutes</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X / Stryker Odenton</b> d. STREET ADDRESS <b>V Ave. and Old Annapolis Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Rufus B. Johnson</b> First Middle Last 4. DATE OF DEATH <b>April 9 1959</b> Month Day Year		5. SEX <b>M</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>11/8/42</b> 9. AGE (In years last birthday) <b>16</b> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b> 11. BIRTHPLACE (State or foreign country) <b>St. Paul Va.</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Rufus Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Marie Jane Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>214-40-3953</b>		17. INFORMANT <b>Mrs. Mary Jane Johnson (mother)</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Self inflicted wound to the right temple with</b> <b>919.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>a 22 gauge pistol, by accident.</b> (c) <b>15 minutes.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was playing with a pistol.</b>	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <b>4/9/59 19 2:10 A.M.</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b> 20f. (City or town) (County) (State) <b>Odenton A.A. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gustave H. Faubert</i> EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>4/10/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>4/13/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Temple Hill</b> 22d. LOCATION (City, town, or county) (State) <b>Castlewood, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping and Kirkley</i> <b>Hopping and Kirkley, Glen Burnie, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 13 '59</b> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3900

## CERTIFICATE OF DEATH

03881

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft Geo G Meade, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> <u>13X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FT GEORGE G. MEADE MD</u>		d. STREET ADDRESS <u>Waterloo Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Dennis</u> Middle <u>Carolie</u> <u>KERSCHNER</u> I		4. DATE OF DEATH Month <u>APRIL</u> Day <u>16</u> Year <u>19 59</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>15 APRIL 1959</u>
9. AGE (In years last birthday) yrs. <u>10</u> Months <u>7</u> Days <u>10</u> Min. <u>7</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>n/a</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>n/a</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13. FATHER'S NAME <u>EDWIN C KERSCHNER</u>	
14. MOTHER'S MAIDEN NAME <u>MARTHA E HARRIER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>n/a</u>		17. INFORMANT <u>MARTHA E KERSCHNER</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs, 7 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-16</u> , 19 <u>59</u> , to <u>4-16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-15</u> , 19 <u>59</u> , and that death occurred at <u>150</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>THOMAS A COOK, JR</u>		M.D. <u>US Army Hosp, Ft George G. Meade, Md</u> <u>16 Apr 59</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS A COOK, JR, MD</u>		<u>US Army Hospital, Ft Geo G Meade, Md</u> <u>16 Apr 59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	22b. DATE THEREOF <u>4-20-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Morgan Land Union Church</u>	22d. LOCATION (City, town, or county) (State) <u>OREFIELD, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR DATE <u>APR 20 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>

2150201XVI



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

03882

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> <u>13X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>		d. STREET ADDRESS <u>Waterloo Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Mark</u> Middle <u>Edwin</u> Last <u>Twin II Kershner</u>		4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>15 April 1959</u>
9. AGE (In years lost birthday) yrs. <u>10</u> <u>1</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>n/a</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Edwin Carolie Kershner</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ellen Harrier</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Father</u>		Address <u>Edwin C. Kershner, Ellicott City, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs 1 min</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-16</u> , 19 <u>59</u> , to <u>4-16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-15</u> , 19 <u>59</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. ARMY HOSPITAL, Ft Geo G Meade, Md</u> <u>16 Apr</u> ACTUAL SIGNATURE <u>THOMAS A COOK, JR, MD</u> PHYSICIAN'S NAME (Type) <u>THOMAS A COOK, JR, MD</u> <u>US Army Hosp, Ft Geo G Meade, Md 16 Apr 59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>4-20-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Morgan Land Union Church</u>		22d. LOCATION (City, town, or county) (State) <u>OREFIELD, Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR DATE <u>APR 20 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Tamm</u>			

2250202x✓1

08883

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1-1-1918

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF DECEASED		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF CLERK		14. SIGNATURE OF JUDGE		15. SIGNATURE OF SHERIFF		16. SIGNATURE OF CORONER		17. SIGNATURE OF MINISTERS		18. SIGNATURE OF OTHERS		19. SIGNATURE OF		20. SIGNATURE OF		21. SIGNATURE OF		22. SIGNATURE OF		23. SIGNATURE OF		24. SIGNATURE OF		25. SIGNATURE OF		26. SIGNATURE OF		27. SIGNATURE OF		28. SIGNATURE OF		29. SIGNATURE OF		30. SIGNATURE OF		31. SIGNATURE OF		32. SIGNATURE OF		33. SIGNATURE OF		34. SIGNATURE OF		35. SIGNATURE OF		36. SIGNATURE OF		37. SIGNATURE OF		38. SIGNATURE OF		39. SIGNATURE OF		40. SIGNATURE OF		41. SIGNATURE OF		42. SIGNATURE OF		43. SIGNATURE OF		44. SIGNATURE OF		45. SIGNATURE OF		46. SIGNATURE OF		47. SIGNATURE OF		48. SIGNATURE OF		49. SIGNATURE OF		50. SIGNATURE OF		51. SIGNATURE OF		52. SIGNATURE OF		53. SIGNATURE OF		54. SIGNATURE OF		55. SIGNATURE OF		56. SIGNATURE OF		57. SIGNATURE OF		58. SIGNATURE OF		59. SIGNATURE OF		60. SIGNATURE OF		61. SIGNATURE OF		62. SIGNATURE OF		63. SIGNATURE OF		64. SIGNATURE OF		65. SIGNATURE OF		66. SIGNATURE OF		67. SIGNATURE OF		68. SIGNATURE OF		69. SIGNATURE OF		70. SIGNATURE OF		71. SIGNATURE OF		72. SIGNATURE OF		73. SIGNATURE OF		74. SIGNATURE OF		75. SIGNATURE OF		76. SIGNATURE OF		77. SIGNATURE OF		78. SIGNATURE OF		79. SIGNATURE OF		80. SIGNATURE OF		81. SIGNATURE OF		82. SIGNATURE OF		83. SIGNATURE OF		84. SIGNATURE OF		85. SIGNATURE OF		86. SIGNATURE OF		87. SIGNATURE OF		88. SIGNATURE OF		89. SIGNATURE OF		90. SIGNATURE OF		91. SIGNATURE OF		92. SIGNATURE OF		93. SIGNATURE OF		94. SIGNATURE OF		95. SIGNATURE OF		96. SIGNATURE OF		97. SIGNATURE OF		98. SIGNATURE OF		99. SIGNATURE OF		100. SIGNATURE OF	
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THE validity of this certificate is dependent upon the truthfulness of the statements made therein. It is the duty of the registrars to see that the statements are true and correct. If they are found to be false or incorrect, the registrars shall be liable for the consequences thereof. This certificate is not valid unless it is signed by the registrars and the witnesses. It is also subject to the provisions of the laws of the State of Maryland relating to the registration of deaths.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3864

Item 9 Film G241 4-30-59 et

## CERTIFICATE OF DEATH

03883

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>x Edgewood</u>	
d. NAME OF HOSPITAL (If at hospital, give street address) OR INSTITUTION <u>C. A. General Hosp.</u>		d. STREET ADDRESS <u>134 10 48</u>	
3. NAME OF DECEASED (Type or print) <u>Hannah Anna Kirby</u>		4. DATE OF DEATH <u>4 20 1959</u>	
5. SEX <u>Female</u>	6. COLOR OF RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-26-1894</u>
9. AGE (In years last birthday) <u>64 65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Levy Gross</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>James Kirby Edgewood, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1</u> <u>Congestive Cardiac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-22-58</u> , 19____, to <u>4-20-59</u> , 19____, that I last saw the deceased alive on <u>4-18-59</u> , 19____, and that death occurred at <u>8:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. J. Allen</u>		DATE SIGNED <u>4-21-59</u>	
PHYSICIAN'S NAME (Type) <u>A. J. ALLEN</u>		ADDRESS (Street, city or town, state) <u>61 Cathedral St</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-23-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer's Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>APR 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. [unclear]</u>	





3902

## CERTIFICATE OF DEATH

03884

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>AA</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MID.</b> b. COUNTY <b>DD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riviera Beach</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Riviera Beach</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MARIN &amp; Canoll Rds</b>				d. STREET ADDRESS <b>1 Main</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>AUGUST Joseph LABER</b>				4. DATE OF DEATH Month Day Year <b>4 - 10 - 1959</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-19-75</b>		9. AGE (In years last birthday) <b>84</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Int. Decorator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Family Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> DUE TO <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio-vascular disease</b> DUE TO (c) <b>Cerebro-vascular accident</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 hours - 2 years - 9 years.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 2, 1954</b> to <b>April 10, 1959</b> , that I last saw the deceased alive on <b>April 10, 1959</b> , and that death occurred at <b>7:00 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R.M. McLaughlin</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>R.F.D. 8 Box 442 Pasadena, Md. April 10, 1959</b>			
PHYSICIAN'S NAME (Type) <b>R.M. McLaughlin</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-14-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>McCully Funeral Home 130 E Fort Ave</b>				24a. REC'D BY REGISTRAR DATE <b>APR 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03885

3865

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>Treadway Maryland Inn</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ERNEST EDWIN LEIPE</u>		4. DATE OF DEATH Month Day Year <u>April 24 19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 26, 1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Switch Board Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Edwin Leipe</u>		14. MOTHER'S MAIDEN NAME <u>Suanna Whittington</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>- - -</u>		16. SOCIAL SECURITY NO. <u>579-09-5671</u>	
17. INFORMANT <u>Mrs. Susanna P. Leitch</u>		Address <u>West St, Annapolis Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO-SCLEROTIC VASCULAR DISEASE</u> DUE TO (c) <u>UNKNOWN</u> INTERVAL BETWEEN ONSET AND DEATH <u>46 DAYS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 APRIL</u> , 19 <u>59</u> , to <u>24 APR</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>24 APRIL</u> , 19 <u>59</u> , and that death occurred at <u>230A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Edward S Beck</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Edward S Beck M.D.</u>		<u>41 Southgate Ave, Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 26, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Edwards Chapel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		ADDRESS <u>Annapolis, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. H...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100



3903

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A. Co.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum Heights</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Linthicum Hgts.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>233 N. Hammonds Ferry Rd.</u>				d. STREET ADDRESS <u>233 N. Hammonds Ferry Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>J.</u> Last <u>McCLOSKEY</u>				4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>19 59</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 24, 1906</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>self emp.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Potato Chips</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>James E. McCloskey</u>				14. MOTHER'S MAIDEN NAME <u>Ella Coffay</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>World War II</u>				16. SOCIAL SECURITY NO. <u>World War II</u>			
17. INFORMANT <u>Mrs. Mary S. McCloskey-233 N. Hammonds Ferry Rd</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of the rectum</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>about 5 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>56</u> , to <u>April 26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 26</u> , 19 <u>59</u> , and that death occurred at <u>6:30p</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>721 Medical Arts Bldg. Balt. 1</u> DATE SIGNED <u>4/27/59</u> ACTUAL SIGNATURE <u>E. Roderick Shipley M.D.</u> PHYSICIAN'S NAME (Type) <u>E. Roderick Shipley, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/30/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Liskner &amp; Sons - Balt. 17th</u>				24a. REG'D BY REGISTRAR DATE <u>APR 28 59</u>		24b. REGISTRAR'S SIGNATURE <u>Christina L. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

83252

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

2203

FILE NO.

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF CORONER</p>		<p>16. SIGNATURE OF JUDGE</p>	
<p>17. SIGNATURE OF CLERK</p>		<p>18. SIGNATURE OF REGISTRAR</p>		<p>19. SIGNATURE OF SHERIFF</p>		<p>20. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>21. SIGNATURE OF SHERIFF'S CLERK</p>		<p>22. SIGNATURE OF SHERIFF'S CLERK</p>		<p>23. SIGNATURE OF SHERIFF'S CLERK</p>		<p>24. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>25. SIGNATURE OF SHERIFF'S CLERK</p>		<p>26. SIGNATURE OF SHERIFF'S CLERK</p>		<p>27. SIGNATURE OF SHERIFF'S CLERK</p>		<p>28. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>29. SIGNATURE OF SHERIFF'S CLERK</p>		<p>30. SIGNATURE OF SHERIFF'S CLERK</p>		<p>31. SIGNATURE OF SHERIFF'S CLERK</p>		<p>32. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>33. SIGNATURE OF SHERIFF'S CLERK</p>		<p>34. SIGNATURE OF SHERIFF'S CLERK</p>		<p>35. SIGNATURE OF SHERIFF'S CLERK</p>		<p>36. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>37. SIGNATURE OF SHERIFF'S CLERK</p>		<p>38. SIGNATURE OF SHERIFF'S CLERK</p>		<p>39. SIGNATURE OF SHERIFF'S CLERK</p>		<p>40. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>41. SIGNATURE OF SHERIFF'S CLERK</p>		<p>42. SIGNATURE OF SHERIFF'S CLERK</p>		<p>43. SIGNATURE OF SHERIFF'S CLERK</p>		<p>44. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>45. SIGNATURE OF SHERIFF'S CLERK</p>		<p>46. SIGNATURE OF SHERIFF'S CLERK</p>		<p>47. SIGNATURE OF SHERIFF'S CLERK</p>		<p>48. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>49. SIGNATURE OF SHERIFF'S CLERK</p>		<p>50. SIGNATURE OF SHERIFF'S CLERK</p>		<p>51. SIGNATURE OF SHERIFF'S CLERK</p>		<p>52. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>53. SIGNATURE OF SHERIFF'S CLERK</p>		<p>54. SIGNATURE OF SHERIFF'S CLERK</p>		<p>55. SIGNATURE OF SHERIFF'S CLERK</p>		<p>56. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>57. SIGNATURE OF SHERIFF'S CLERK</p>		<p>58. SIGNATURE OF SHERIFF'S CLERK</p>		<p>59. SIGNATURE OF SHERIFF'S CLERK</p>		<p>60. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>61. SIGNATURE OF SHERIFF'S CLERK</p>		<p>62. SIGNATURE OF SHERIFF'S CLERK</p>		<p>63. SIGNATURE OF SHERIFF'S CLERK</p>		<p>64. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>65. SIGNATURE OF SHERIFF'S CLERK</p>		<p>66. SIGNATURE OF SHERIFF'S CLERK</p>		<p>67. SIGNATURE OF SHERIFF'S CLERK</p>		<p>68. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>69. SIGNATURE OF SHERIFF'S CLERK</p>		<p>70. SIGNATURE OF SHERIFF'S CLERK</p>		<p>71. SIGNATURE OF SHERIFF'S CLERK</p>		<p>72. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>73. SIGNATURE OF SHERIFF'S CLERK</p>		<p>74. SIGNATURE OF SHERIFF'S CLERK</p>		<p>75. SIGNATURE OF SHERIFF'S CLERK</p>		<p>76. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>77. SIGNATURE OF SHERIFF'S CLERK</p>		<p>78. SIGNATURE OF SHERIFF'S CLERK</p>		<p>79. SIGNATURE OF SHERIFF'S CLERK</p>		<p>80. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>81. SIGNATURE OF SHERIFF'S CLERK</p>		<p>82. SIGNATURE OF SHERIFF'S CLERK</p>		<p>83. SIGNATURE OF SHERIFF'S CLERK</p>		<p>84. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>85. SIGNATURE OF SHERIFF'S CLERK</p>		<p>86. SIGNATURE OF SHERIFF'S CLERK</p>		<p>87. SIGNATURE OF SHERIFF'S CLERK</p>		<p>88. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>89. SIGNATURE OF SHERIFF'S CLERK</p>		<p>90. SIGNATURE OF SHERIFF'S CLERK</p>		<p>91. SIGNATURE OF SHERIFF'S CLERK</p>		<p>92. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>93. SIGNATURE OF SHERIFF'S CLERK</p>		<p>94. SIGNATURE OF SHERIFF'S CLERK</p>		<p>95. SIGNATURE OF SHERIFF'S CLERK</p>		<p>96. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>97. SIGNATURE OF SHERIFF'S CLERK</p>		<p>98. SIGNATURE OF SHERIFF'S CLERK</p>		<p>99. SIGNATURE OF SHERIFF'S CLERK</p>		<p>100. SIGNATURE OF SHERIFF'S CLERK</p>	

FILE NO.

FILE NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3866

## CERTIFICATE OF DEATH

03888

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6-Bowie Ave</u>		d. STREET ADDRESS <u>16-Bowie Ave</u>	
3. NAME OF DECEASED (Type or print) <u>(Westley) Sylvester McGOWANS</u>		4. DATE OF DEATH Month <u>4</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-28-1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Anne Arundel Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>Westley McGOWANS</u>		14. MOTHER'S MAIDEN NAME <u>SALLIE WELLS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MARY Ida Parker</u>		Address <u>BALT. 23-Md. Pentose Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1</u> DUE TO <u>Congestive Cardiac Failure</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <u>—</u>			
(c) DUE TO <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-26-59</u> , 19 <u>59</u> , to <u>4-27-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-26-59</u> , 19 <u>59</u> , and that death occurred at <u>7:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>4-29-59</u>	
PHYSICIAN'S NAME (Type) <u>A.T. ALLEN</u>		Address <u>ANNAPOLIS MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-1-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. CALVARY</u>		22d. LOCATION (City, town, or county) (State) <u>Arnold-A.A.Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks</u>		ADDRESS <u>ANNAPOLIS-MD</u>	
24a. REC'D BY REGISTRAR <u>MAY 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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Item 8, Film G241, 4/17/59 fcy  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**CERTIFICATE OF DEATH**

03889  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Orchard Beach (Balto. 26)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Orchard Beach (Balto. 26)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2028 Fernhill Rd.</u>				e. STREET ADDRESS <u>2028 Fernhill Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>THEODORE</u> Middle <u>J.</u> Last <u>MISTER</u>				4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>19 59</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1868</u> <u>Sept. 26, 1868</u>	9. AGE (In years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>rtd</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Transit Co</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Josuha Mister</u>				14. MOTHER'S MAIDEN NAME <u>Amanda --</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Walter R. Mister - 2028 Fernhill Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-vascular disease</u> DUE TO (c) <u>5 years.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 10</u> , 19 <u>53</u> , to <u>April 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 7</u> , 19 <u>59</u> , and that death occurred at <u>1:56 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. M. McLaughlin</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>RFD 8 Box 442 Pasadena, Md. April 7, 1959</u>			
PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner &amp; Sons - Balto. Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	



CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. PLACE OF DEATH</p> <p>14. TIME OF DEATH</p> <p>15. SIGNATURE OF PHYSICIAN</p> <p>16. SIGNATURE OF REGISTRAR</p> <p>17. DATE OF DEATH</p> <p>18. COUNTY</p> <p>19. CITY</p> <p>20. STATE</p> <p>21. ZIP CODE</p> <p>22. COUNTY</p> <p>23. CITY</p> <p>24. STATE</p> <p>25. ZIP CODE</p>		<p>26. SIGNATURE OF PHYSICIAN</p> <p>27. SIGNATURE OF REGISTRAR</p> <p>28. DATE OF DEATH</p> <p>29. COUNTY</p> <p>30. CITY</p> <p>31. STATE</p> <p>32. ZIP CODE</p>
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1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. COLOR

9. RELIGION

10. EDUCATION

11. PREVIOUS ILLNESS

12. CAUSE OF DEATH

13. PLACE OF DEATH

14. TIME OF DEATH

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF REGISTRAR

17. DATE OF DEATH

18. COUNTY

19. CITY

20. STATE

21. ZIP CODE

22. COUNTY

23. CITY

24. STATE

25. ZIP CODE

3867

## CERTIFICATE OF DEATH

03890  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN lb <u>75 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>063 Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>R.</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>4</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/12, 1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Capt. U.S. Air Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Jackson Moore</u>		14. MOTHER'S MAIDEN NAME <u>Ella Talbert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>217-30-3324</u>		16. SOCIAL SECURITY NO. <u>217-30-3324</u>	
17. INFORMANT <u>Catherine F. Liberty</u> <u>Daughter</u> <u>above address - 1st</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Purulent bronchitis + asphyxia with unresolved pneumonia</u> 502.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nephrosclerosis nephrolithiasis - Abdominal aortic aneurysm</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 21, 1959</u> , to <u>April 15, 1959</u> , that I last saw the deceased alive on <u>April 15, 1959</u> , and that death occurred at <u>8:31 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Marving W. Alden</u>		ADDRESS (Street, city or town, state) <u>Anne Arundel Co. Md.</u> DATE SIGNED <u>4-16-59</u>	
PHYSICIAN'S NAME (Type) <u>Marving W. Alden</u>		<u>Annapolis, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/18/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home</u>		24. REGISTRAR'S SIGNATURE <u>C. L. Thoms</u>	
ADDRESS <u>md. Rainier</u>		DATE <u>APR 20 1959</u>	

1

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

2000. 1. 1. 1000

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3905

## CERTIFICATE OF DEATH

05119

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>1yr. 2mo. 28da.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Willie Parker</b>				4. DATE OF DEATH Month <b>4</b> Day <b>26</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/10/79</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>			
13. FATHER'S NAME <b>Jake Parker</b>				14. MOTHER'S MAIDEN NAME <b>Cornelia Holliman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Decubital Ulcers, Gangrenous</b> DUE TO <b>Inanition Associated with Cerebral Thrombosis with Hemiparesis</b> (c) <b>with Hemiparesis</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>--</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>1958</b>				20g. (County) <b>4/26</b>		20h. (State) <b>1959</b>	
21. I certify that I attended the deceased from <b>1/28</b> , 19 <b>58</b> , to <b>4/26</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>4/26</b> , 19 <b>59</b> , and that death occurred at <b>4:20 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. Benedict</b>				ADDRESS (Street, city or town, state) <b>Crownsville, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>L. Benedict, M.D.</b>				DATE SIGNED <b>Crownsville State Hospital, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/7/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hospital Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crownsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George McK. Phillips</b>				ADDRESS <b>Crownsville</b>		24a. REC'D BY REGISTRAR <b>MAY 8 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanks</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3868

CERTIFICATE OF DEATH

03891

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i> <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>10-11-2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. C. General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Raymond Ellsworth Pettingall Sr.</i>		4. DATE OF DEATH Month <i>4</i> - Day <i>27</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 21-1894</i>
9. AGE (In years last birthday) <i>64</i> yrs.		10. IF UNDER 1 YEAR Months <i>6</i> Days <i>4</i> Hours <i>27</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machineist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Brush Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	
13. FATHER'S NAME <i>Winfield Scott Pettingall</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Ann Fyler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-10-2349</i>	
17. INFORMANT <i>Mrs. Nan B. Pettingall-Same as Item #2</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <i>Myocardial infarction</i> (c) <i>arteriosclerotic cardiovascular disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 minutes</i> <i>11 days</i> <i>3 years</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/16</i> , 19 <i>59</i> , to <i>4/26</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>4/27</i> , 19 <i>59</i> , and that death occurred at <i>5:50</i> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Sylvia M. Lim</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>Marys Road Edgewater 4-27-59</i>	
PHYSICIAN'S NAME (Type) <i>Sylvia M. Lim, M. D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Apr. 30, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mount Olivet Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Frederick, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>M. R. Etchison &amp; Son, Frederick, Maryland</i>		24a. REC'D BY REGISTRAR DATE <i>APR 28 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>			

10801

CERTIFICATE OF DEATH

1980

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3906

## CERTIFICATE OF DEATH

03892

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>AA</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Severn Avenue</b>				d. STREET ADDRESS <b>Severn Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) First <b>AURVIN</b> Middle <b>JOHN</b> Last <b>PFEIFFER</b>				<b>4. DATE OF DEATH</b> Month <b>APRIL</b> Day <b>10</b> Year <b>1959</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Sept 12, 1894</b>	
<b>9. AGE</b> (In years last birthday) <b>64</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Ret. Paper Hanger</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Md.</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>							
<b>13. FATHER'S NAME</b> <b>George Pfeiffer</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Sophie Miller</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes or no or unknown) <b>no</b>				<b>16. SOCIAL SECURITY NO.</b> <b>215-07-9294</b>		<b>17. INFORMANT</b> Address <b>Mrs Alma S. Pfeiffer-Wife- Same as # 2</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vascular Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>5 hours</b> <b>4 years</b>							
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (If either, notify medical examiner)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <b>April 1956</b> , to <b>April 10, 1959</b> , that I last saw the deceased alive on <b>April 10, 1959</b> , and that death occurred at <b>7:55 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5010 A Pacific Ave Baltimore 25</b> DATE SIGNED <b>April 11 '59</b> ACTUAL SIGNATURE <b>Benjamin Berdman</b> M.D. PHYSICIAN'S NAME (Type) <b>Hopping and Kirkley, Glen Burnie, Md.</b>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>April 13, 59</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Glen Haven Cemetery</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Glen Burnie, Maryland</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Hopping and Kirkley, Glen Burnie, Md.</b>				<b>24a. REC'D BY REGISTRAR</b> DATE <b>APR 14 '59</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Charles S. Horne</b>	

CERTIFICATE OF DEATH

2908

08892

For Use By

<p>1. NAME OF DECEASED                  JAMES HENRY                  2. SEX                  M                  3. AGE                  45                  4. DATE OF BIRTH                  1893</p>		<p>5. PLACE OF BIRTH                  BALTIMORE, MARYLAND                  6. OCCUPATION                  LABORER                  7. MARITAL STATUS                  SINGLE</p>	
<p>8. DATE OF DEATH                  1938                  9. TIME OF DEATH                  10. PLACE OF DEATH                  BALTIMORE, MARYLAND</p>		<p>11. CAUSE OF DEATH                  12. MANNER OF DEATH                  13. MEDICAL HISTORY                  14. PREVIOUS ILLNESS</p>	
<p>15. SIGNATURE OF PHYSICIAN                  16. SIGNATURE OF REGISTRAR                  17. SIGNATURE OF WITNESSES</p>		<p>18. COUNTY OF DEATH                  19. CITY OF DEATH                  20. STATE OF DEATH</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3869

CERTIFICATE OF DEATH

03893

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>D. A.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PASADENA</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>1 MILL ROAD</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Baby boy</b> Middle <b>Phelps</b> Last <b>Phelps</b>				4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 11, 1959</b>	
9. AGE (In years last birthday) <b>— yrs.</b>		10. IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>14</b> Min. <b>10</b>		11. BIRTHPLACE (State or foreign country) <b>Annapolis, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>			
13. FATHER'S NAME <b>Kenneth Godfrey Phelps</b>				14. MOTHER'S MAIDEN NAME <b>Shirley Patricia Wirth</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>—</b>			
INFORMANT <b>Mother</b>				Address <b>Rt. 9, Box 77, Mill Rd., Pasadena, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b> 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> DUE TO (c) <b>—</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b> INTERVAL BETWEEN ONSET AND DEATH <b>14 hrs.</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 11, 1959</b> to <b>April 12, 1959</b> that I last saw the deceased alive on <b>April 12, 1959</b> , and that death occurred at <b>10:15 M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Neil H. Sims</b> M.D.				ADDRESS (Street, city or town, state) <b>95 Cathedral Street</b> DATE SIGNED <b>4/13/59</b>			
PHYSICIAN'S NAME (Type) <b>Annapolis</b>				<b>Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/14/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>LODON PARK Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry J. Bone</b>				ADDRESS <b>4001 Ritchie Hwy.</b>			
24a. REC'D BY REGISTRAR <b>APR 17 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>			

20632301XV4





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3907

## CERTIFICATE OF DEATH

03894

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shadyside</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shadyside, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>LIDA</u> First <u>ESTELLA</u> Middle <u>PHIPPS</u> Last		4. DATE OF DEATH <u>April</u> Month <u>14</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 22</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Phoenix Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Stephen A. Lusby</u>		14. MOTHER'S MAIDEN NAME <u>Sally Norwood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Dorothy M. Phipps</u> Address <u>Shadyside Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction &amp; dehydration</u> <u>154X</u> DUE TO <u>Carcinoma of recto sigmoid colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>unknown</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 19</u> , 19 <u>59</u> , to <u>April 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 14</u> , 19 <u>59</u> , and that death occurred at <u>3:45 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>Shadyside, Maryland</u> DATE SIGNED <u>4/14/59</u>	
PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH, MD</u>		<u>SHADYSIDE, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 17/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Luttrell</u>	22d. LOCATION (City, town, or county) (State) <u>Littlesville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bruce Hardaway</u> ADDRESS <u>Salisbury</u>		24a. REC'D BY REGISTRAR DATE <u>APR 20 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3908

## CERTIFICATE OF DEATH

03895

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>A.A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Churchton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Churchton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>Rogers Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MAMIE</b> Middle <b>POWELL</b> Last <b>POWELL</b>		4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 18.81</b>
9. AGE (In years last birthday) <b>77 yrs.</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>19</b> Min.	11. IF UNDER 24 HRS. Months <b>7</b> Days <b>19</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Govt.</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Richard H. Powell</b>		14. MOTHER'S MAIDEN NAME <b>Laura Toombs</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Beatrice M. Davis</b>		Address <b>Churchton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Arteriosclerosis &amp; hypertensive</b> DUE TO (c) <b>cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 12, 1959</b> , to <b>April 19, 1959</b> , that I last saw the deceased alive on <b>April 19, 1959</b> , and that death occurred at <b>9:54 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Willard F. Smith</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>Shadyside, Maryland 4/19/59</b>	
PHYSICIAN'S NAME (Type) <b>WILLARD F. SMITH, MD</b>		<b>SHADYSIDE, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4-23-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL</b>		22d. LOCATION (City, town, or county) (State) <b>SUITLAND, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LEE FUNERAL HOME</b>		ADDRESS <b>WASHINGTON D.C.</b>	
24a. REC'D BY REGISTRAR <b>APR 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3909

## CERTIFICATE OF DEATH

03896

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <b>AnneArundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft George G. Meade,</b>		c. LENGTH OF STAY IN 1b <b>1day</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Hanover</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S.Army Hospital</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>6 Mulberry Rd</b>	
3. NAME OF DECEASED (Type or print) First <b>MILTON</b> Middle <b>CHARLES</b> Last <b>POWERS</b>		4. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7 Feb 1897</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AMERICAN ICE CO., RETIRED</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>US</b>		13. FATHER'S NAME <b>Joseph Powers</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth Young</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>214-01-5103</b>		17. INFORMANT <b>Son-in-law</b> <b>M/Sgt Dugal M. Neilson, 6 Mulberry Rd Hanover, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>7 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2 April</b> , 19 <b>59</b> , to <b>2 April</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2 April</b> , 19 <b>59</b> , and that death occurred at <b>0815A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S.Army Hospital, Ft Meade, Md</b> DATE SIGNED <b>2Apr 59</b> ACTUAL SIGNATURE <b>George B. Hagan</b> M.D. PHYSICIAN'S NAME (Type) <b>GEORGE B. HAGAN, Capt, MC</b> <b>U.S.Army Hosp, Ft Geo G. Meade, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/6/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS INC. BALTIMORE MD.</b>		24a. REC'D BY REGISTRAR <b>APR 6 1959</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hagan</b>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3870

CERTIFICATE OF DEATH

03897  
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. STREET ADDRESS <u>513 Oak Lawn Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Bessie C. Randall</u>		4. DATE OF DEATH Month <u>4</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-19-1894</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>19</u> Min.	11. IF UNDER 24 HRS. Months <u>4</u> Days <u>4</u> Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTH PLACE (State or foreign country) <u>Calvert Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Isaac Sawlings</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Purulent Bronchitis, Pneumonia</u> DUE TO <u>And Broncho-Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Delayed Hydrocephalus &amp; hypertensive cerebral and cardiac</u> DUE TO <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/28/59</u> to <u>4/4/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/4/59</u> , 19 <u>59</u> , and that death occurred at <u>110-Clay St ANNAPOLIS MD</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. L. Richardson</u>		DATE SIGNED <u>4/5/59</u>	
PHYSICIAN'S NAME (Type) <u>R. L. RICHARDSON</u>		ADDRESS (Street, city or town, state) <u>110-Clay St ANNAPOLIS MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-7-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Peters Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Dunkirk Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Geese, W. Lynn. Md.</u>		24a. REC'D BY REGISTRAR <u>APR 7 59</u>	
ADDRESS <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

10234

CERTIFICATE OF DEATH

0580

10234

10234

10234

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10234

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05128

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>AA</b> <span style="float: right;">3910</span> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Davidsonville</b>		c. LENGTH OF STAY in 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ---		d. STREET ADDRESS ---	
3. NAME OF DECEASED (Type or print) <b>First EDWARD Middle A Last RITTER</b>		4. DATE OF DEATH Month <b>4</b> Day <b>25</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 4, 1959</b>
9. AGE (In years last birthday) yrs. <b>2</b> Months <b>21</b> Days <b>21</b> Hours <b>Min.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Edward Allen Ritter</b>		14. MOTHER'S MAIDEN NAME <b>Pauline Hill</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. ---	
17. INFORMANT <b>Edward Allen Ritter-</b>		Address <b>Davidsonville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHO PNEUMONIA</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20b. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.	
20c. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Paul F. Guerin</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>PAUL F. GUERIN</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>4-26-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/28/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hebron Center</b>		22d. LOCATION (City, town, or county) (State) <b>Davidsonville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Upper Marlboro, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 11 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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FOR STATE  
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05138

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3911 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 7,8,9 Film G241 4-24-59 et

03898

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Holly Hill Harbor</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		f. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Richard</u> First <u>Rush</u> Middle <u>Seek</u> Last		4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>October 13, 1899</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David O. Seek</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bradecamp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>David O. Seek, Jr.</u>		Address <u>5711 Heger Rd. Hyattsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun Shot Wound</u> 976X DUE TO <u>Shoulder w/ Chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted gun shot wound</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> p. m. <u>4:14</u> 19 <u>59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Hyattsville</u> <u>Md.</u> <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. L. Wharfed</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. Wharfed</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/18/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		24a. REC'D BY REGISTRAR DATE <u>APR 20 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



3912

## CERTIFICATE OF DEATH

Reg. Dist. No.

MEDICAL CERTIFICATION	1. PLACE OF DEATH a. COUNTY <u>AA</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>						
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camel Beach, MD</u>		c. LENGTH OF STAY IN 1b <u>-</u>						
	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>412 Camel Beach Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
	3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>James</u> Last <u>Short</u>		4. DATE OF DEATH Month <u>11</u> Day <u>23</u> Year <u>1909</u>						
	5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 26, 1894</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.		
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. ARMY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>W. VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
	13. FATHER'S NAME <u>Nart Short</u>		14. MOTHER'S MAIDEN NAME <u>Eva Sinclair</u>						
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Family</u> Address <u>Same</u>				
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Sclerosis</u> DUE TO (c) <u>2 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>		
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 19, 1950</u> to <u>April 23, 1959</u> , that I last saw the deceased alive on <u>April 17, 1959</u> , and that death occurred at <u>MD</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>RIVIERA BEACH</u> DATE SIGNED <u>4/26/59</u> ACTUAL SIGNATURE <u>J. Brady Smith</u> M.D. <u>J. BRADY SMITH</u> PHYSICIAN'S NAME (Type) <u>PASADENA, MARYLAND</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-27-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes</u>				ADDRESS <u>130 E. Fort Ave</u>		24a. REC'D BY REGISTRAR DATE <u>APR 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knapp</u>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

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CERTIFICATE OF DEATH

Page One of Two

1. Name of Deceased (Print Name) JAMES EARL RAY		2. Date of Birth 10-14-1928	
3. Sex Male		4. Race White	
5. Date of Death 4-4-68		6. Place of Death FARMINGTON, MD	
7. Cause of Death (List Cause) Suicide by gunshot wound of the chest		8. Manner of Death Suicide	
9. Physician's Name DR. J. W. BROWN		10. Hospital or Clinic FARMINGTON HOSPITAL	
11. Signature of Physician J. W. BROWN		12. Signature of Registrar J. W. BROWN	
13. Date of Signature 4-4-68		14. Place of Signature FARMINGTON, MD	



3871

## CERTIFICATE OF DEATH

03900

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>aa.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. C. General</i>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Davidsonville</i>			
				f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Samuel</i> Middle <i>H.</i> Last <i>Starlings</i>				4. DATE OF DEATH Month <i>4</i> - Day <i>23</i> Year <i>1959</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan. 6 1890</i>	
				9. AGE (In years last birthday) <i>69</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Wheat Corn Etc</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>							
13. FATHER'S NAME <i>William Starlings</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Laura V. Starlings</i> Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL HEMORRHAGE</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>HYPERTENSIVE VASCULAR DISEASE</i> DUE TO (c) <i>Unknown</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>DIABETES MELLITUS</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>JAN. 1956</i> , to <i>23 APRIL, 1959</i> , that I last saw the deceased alive on <i>23 APRIL, 1959</i> , and that death occurred at <i>2:50 P.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Edward A. Beck</i> M.D.				ADDRESS (Street, city or town, state) <i>Southgate Ave. Annapolis MD</i>			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4-27-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest Mem.</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Sayla Sons</i> ADDRESS <i>Annapolis MD</i>				24a. REC'D BY REGISTRAR DATE <i>APR 27 59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, at removal, and in any event within 72 hours after death.

41  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3913 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
Item 7 Film G242 5-18-59 et

03901

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rivere Beach, Pasadena</b> c. LENGTH OF STAY IN lb <b>3hrs.</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Monroe, Key West,</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>48x-3</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>In the woods, off Hilltop Rd.</b>			d. STREET ADDRESS <b>Motor Vessel, Savannas Garison</b>		
3. NAME OF DECEASED (Type or print) <b>Charles George Taylor</b>			4. DATE OF DEATH <b>April 10th, 1959</b>		
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>Separated</b>	
8. DATE OF BIRTH <b>4/19/03</b>		9. AGE (in years last birthday) <b>55 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Diver (Water)</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Carabou, N.B. Canada</b>		13. CITIZEN OF WHAT COUNTRY <b>USA</b>	
14. FATHER'S NAME <b>George Taylor</b>			15. MOTHER'S MAIDEN NAME <b>?</b>		
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			17. SOCIAL SECURITY NO. <b>110-09-0611</b>		
18. INFORMANT <b>Raymond Taylor (son)</b>			Address <b>Revere Beach, Pasadena, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Self inflicted wound through the right temple</b> DUE TO (b) <b>with a pistol gauge 22. (Suicide).</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>As stated in Part 18,</b>		
20c. TIME OF INJURY Month, Day, Year <b>3.30 a.m. 4/10/59 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Woods</b>	
20f. (City or town) <b>Revere Beach, A.A. Md.</b>		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Gustave H. Faubert, M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <b>4/10/59</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/13/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial</b>	
22d. LOCATION (City, town, or county) <b>Glen Burnie, Md.</b>		22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping and Kirkley</b>			24a. REC'D BY REGISTRAR <b>APR 13 '59</b>		
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>			DATE		

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3914

## CERTIFICATE OF DEATH

03902

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>8mo. 21days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>549 W. Biddle Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Lee</b> Last <b>Taylor</b>		4. DATE OF DEATH Month <b>4</b> Day <b>7</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/6/93</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Washington</b>		14. MOTHER'S MAIDEN NAME <b>Sally Garrat</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>213-18-3509</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis and Hypertension</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hemiplegia (right), Edema of right legs, fractured right hip &amp; epilepsy</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----- 20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- 19 p. m. ----- 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----- 20f. (City or town) (County) (State) ----- 21. I certify that I attended the deceased from <b>7/16</b> <b>1958</b> to <b>4/7</b> <b>1959</b> , that I last saw the deceased alive on <b>4/7</b> <b>1959</b> , and that death occurred at <b>5:55 A.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Crownsville State Hospital, Md. 4/7/59</b> ACTUAL SIGNATURE <b>Lionel McHenry Mapp, M. D.</b> PHYSICIAN'S NAME (Type) <b>Crownsville State Hospital, Md. 4/7/59</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b> 22b. DATE THEREOF <b>April 19, 1959</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b> 22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b> 23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Hensley</b> ADDRESS <b>578 W Biddle St</b> 24a. REC'D BY REGISTRAR <b>APR 13 1959</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hensley</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
 Items 13 & 14, Film G241 4/16/59  
**3872**  
**CERTIFICATE OF DEATH**

**03903**  
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>C. C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>C. C. General Hosp.</i>		d. STREET ADDRESS <i>52 C. Creek Terrace</i>	
3. NAME OF DECEASED (Type or print) First <i>Garfield</i> Middle <i>Thomas</i> Last <i>Thomas</i>		4. DATE OF DEATH Month <i>4</i> Day <i>9</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-25-1889</i>
9. AGE (In years lost birthday) <i>70</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Naval Acad. Mt. Zion, Md.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Harrison Thomas</i>		14. MOTHER'S MAIDEN NAME <i>Rachel ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NO</i>	
17. INFORMANT <i>Lucia Thomas - Annapolis, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>malnutrition &amp; stomach</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4-9-59</i> to <i>4-9-59</i> , that I last saw the deceased alive on <i>4-9-59</i> , 19 <i>59</i> , and that death occurred at <i>5:45</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>G. T. Allen</i>		ADDRESS (Street, city or town, state) <i>62 Chestnut St Annapolis, Md.</i>	
PHYSICIAN'S NAME (Type) <i>A T ALLEN</i>		DATE SIGNED <i>APR 13 1959</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4-13-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr. Annapolis, Md.</i>		24a. REC'D BY REGISTRAR <i>APR 13 1959</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Howard</i>			

1875

CERTIFICATE OF DEED

3735

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3915

Item 12, Film G242,5-14-59, mmd

## CERTIFICATE OF DEATH

03904

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HA.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HA.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>		c. LENGTH OF STAY IN 1b <u>50</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2-1st Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Theresa A</u> Middle <u>Thomas</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>4</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-29-83</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>CHAK</u>		14. MOTHER'S MAIDEN NAME <u>Galt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Family - Same</u>	
17. INFORMANT <u>Family - Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hypertensive cardio-vascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1959</u> , to <u>Apr 6, 1959</u> , that I last saw the deceased alive on <u>Apr. 5, 1959</u> , and that death occurred at <u>1021</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip W. Keister M.D.</u>		ADDRESS (Street, city or town, state) <u>302 Patapsco Ave</u> DATE SIGNED <u>4/6/59</u>	
PHYSICIAN'S NAME (Type) <u>KEISTER</u>		<u>BALTO 25 RD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>25</u>		22b. DATE THEREOF <u>4-9-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Edgemoor</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO 25 RD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Home, 237 Patapsco Ave.</u>		ADDRESS <u>Brooklyn, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thane</u>	





## CERTIFICATE OF DEATH

03905

Reg. Dist. No.

3918

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn Park</b>				c. LENGTH OF STAY IN 1b <b>35yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5 Seventh Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Estelle</b> Middle <b>White</b> Last <b>Van Wicklen</b>				4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 14, 1889</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Maryland Chenowith</b> Address <b>Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Breast, metastatic</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of left breast</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b> <b>7 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive Cardiovascular Disease</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>November</b> , 19 <b>50</b> , to <b>April 28</b> , 19 <b>59</b> , that I lost the deceased on <b>April 28</b> , 19 <b>59</b> , and that death occurred at <b>3:00</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Benjamin Berdamm</b> M.D.				ADDRESS (Street, city or town, state) <b>5010 A Ritchie Hwy</b> DATE SIGNED <b>Apr 30 1959</b>			
PHYSICIAN'S NAME (Type) <b>BENJAMIN BERDANN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 1, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Ritchie Hwy. A. A. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Jones</b> ADDRESS <b>4001 Ritchie Hwy. (25)</b>				24a. REC'D BY REGISTRAR <b>MAY 5 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 3917 CERTIFICATE OF DEATH

03906

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>A. A. Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MILLERSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MILLERSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SANN'S NURSING HOME</b>		d. STREET ADDRESS <b>RT. #1 BOX 361B</b>	
3. NAME OF DECEASED (Type or print) First <b>EDITH</b> Middle <b>M.</b> Last <b>WAGNER</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 4, 1888</b>
9. AGE (In years last birthday) <b>70</b> yn.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>THOMAS GWEN</b>		14. MOTHER'S MAIDEN NAME <b>HARDY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>JEAN NEWBERGER</b>		Address <b>MILLERSVILLE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Heart Failure</b> <b>174X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Massive hemorrhage (uterine)</b> DUE TO <b>Carcinoma Uterus.</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiovascular Disease - Twenty years</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 Year</b>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 8, 1959</b> to <b>April 3, 1959</b> and that I last saw the deceased alive on <b>April 2, 1959</b> , and that death occurred at <b>7:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>DR. JOSEPH LIPSKEY</b>		DATE SIGNED <b>4-3-59</b>	
PHYSICIAN'S NAME (Type) <b>COENTON, MARYLAND</b>		ADDRESS (Street, city or town, state) <b>Clinton, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-6-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lowdon Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Johnson</b>		ADDRESS <b>1359 W. Ash Blvd. Baltimore</b>	
24a. REC'D BY REGISTRAR <b>APR 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

83408

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

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DR. JOSEPH LIBSKY  
Dorchester, Mass.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 8, 9 Film 6241 4-20-59 et  
3918  
CERTIFICATE OF DEATH

03907  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>35 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>2109 E. Chase St.</u>	
3. NAME OF DECEASED (Type or print) <u>GEORGE</u>		4. DATE OF DEATH Month <u>4</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1881</u> <u>8-3-1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unkn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unkn</u>	
11. BIRTHPLACE (State or foreign country) <u>Unkn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>C.S.H Medical records # 19459</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Inanition and Dehydration</u> (c) <u>Bronchogenic Carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Known as Stage 2-27-59</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. --- 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 27</u> , 19 <u>59</u> , to <u>April 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 3</u> , 19 <u>59</u> , and that death occurred at <u>11:35</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stanley C. Sargeant</u> M.D. <u>Crownsville Md.</u>		DATE SIGNED <u>4-4-59</u>	
PHYSICIAN'S NAME (Type) <u>Stanley C. Sargeant, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 9, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rayner Sanders</u> ADDRESS <u>217 E. Preston St.</u>		24a. REC'D BY REGISTRAR <u>APR 6 '59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	



CERTIFICATE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO WARD

DATE OF ENTRY INTO BLOCK

DATE OF ENTRY INTO HOUSE

DATE OF ENTRY INTO ROOM

DATE OF ENTRY INTO BED

DATE OF ENTRY INTO CLOSET

DATE OF ENTRY INTO DRESSING ROOM

DATE OF ENTRY INTO BATHROOM

DATE OF ENTRY INTO KITCHEN

DATE OF ENTRY INTO LIVING ROOM

DATE OF ENTRY INTO PORCH

DATE OF ENTRY INTO GARAGE

DATE OF ENTRY INTO DRIVE

DATE OF ENTRY INTO YARD

DATE OF ENTRY INTO GARDEN

DATE OF ENTRY INTO PATIO

DATE OF ENTRY INTO TERRACE

DATE OF ENTRY INTO BALCONY

DATE OF ENTRY INTO PORCH

DATE OF ENTRY INTO GARAGE

DATE OF ENTRY INTO DRIVE

DATE OF ENTRY INTO YARD

DATE OF ENTRY INTO GARDEN

DATE OF ENTRY INTO PATIO

DATE OF ENTRY INTO TERRACE

DATE OF ENTRY INTO BALCONY

DATE OF ENTRY INTO PORCH

DATE OF ENTRY INTO GARAGE

DATE OF ENTRY INTO DRIVE

DATE OF ENTRY INTO YARD

DATE OF ENTRY INTO GARDEN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 241 4-17-59 ams Film G241, 4/17/59 fcy  
3919  
CERTIFICATE OF DEATH

03908  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <b>County</b> <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville</b>		c. LENGTH OF STAY IN 1b <b>X Millersville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sann's Nursing Home</b>		d. STREET ADDRESS <b>/</b>	
e. IS RESIDENCE ONLY A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>TURNER</b> Middle <b>ROBERT</b> Last <b>WATSON</b>		4. DATE OF DEATH Month <b>April</b> Day <b>8,</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 4, 1880</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tabacco</b>	11. BIRTHPLACE (State or foreign country) <b>Millersville, Md</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Truman A. Watson</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Turner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs Delma Upton-Daughter-</b>		Address <b>Pasadena, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive vascular Arteriosclerosis diseases.</b> <b>443 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture of right hip</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 months.</b> <b>3 months</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>20th. March 1959</b> , to <b>4/8/59</b> , that I last saw the deceased alive on <b>4/8/59</b> , and that death occurred at <b>11.05PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Gustave H. Faubert MD</b> <b>4/9/59</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>Gustave H. Faubert MD</b> <b>Glen Burnie, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-11-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baldwin Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Millersville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOPPING AND KIRKLEY</b>		ADDRESS <b>Glen Burnie, Md.</b>	
24a. REC'D BY REGISTRAR <b>APR 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>	

05908

CERTIFICATE OF DEATH

1. NAME AND SEX OF DECEASED JAMES A. BROWN		2. AGE 45	
3. DATE OF DEATH 1912-11-15		4. PLACE OF DEATH Home	
5. TIME OF DEATH 10:30 AM		6. CAUSE OF DEATH Typhoid fever	
7. PLACE OF BIRTH Maryland		8. OCCUPATION Farmer	
9. MARITAL STATUS Married		10. EDUCATION High School	
11. RELIGION Methodist		12. SIGNATURE OF DECEASED James A. Brown	
13. SIGNATURE OF WITNESSES John Doe, Jane Smith		14. SIGNATURE OF PHYSICIAN Dr. John Doe	
15. SIGNATURE OF REGISTRAR John Doe		16. SIGNATURE OF CLERK John Doe	
17. SIGNATURE OF JUDGE John Doe		18. SIGNATURE OF SHERIFF John Doe	
19. SIGNATURE OF CORONER John Doe		20. SIGNATURE OF JURY John Doe	
21. SIGNATURE OF DISTRICT ATTORNEY John Doe		22. SIGNATURE OF COUNTY CLERK John Doe	
23. SIGNATURE OF STATE CLERK John Doe		24. SIGNATURE OF SECRETARY John Doe	
25. SIGNATURE OF ASSISTANT SECRETARY John Doe		26. SIGNATURE OF CHIEF CLERK John Doe	
27. SIGNATURE OF DEPUTY CHIEF CLERK John Doe		28. SIGNATURE OF RECORDS CLERK John Doe	
29. SIGNATURE OF INDEXING CLERK John Doe		30. SIGNATURE OF FILE CLERK John Doe	
31. SIGNATURE OF DISTRIBUTION CLERK John Doe		32. SIGNATURE OF RETURN CLERK John Doe	
33. SIGNATURE OF COLLECTION CLERK John Doe		34. SIGNATURE OF ACCOUNTING CLERK John Doe	
35. SIGNATURE OF AUDITING CLERK John Doe		36. SIGNATURE OF INSPECTION CLERK John Doe	
37. SIGNATURE OF COMPLAINT CLERK John Doe		38. SIGNATURE OF INVESTIGATION CLERK John Doe	
39. SIGNATURE OF PREVENTION CLERK John Doe		40. SIGNATURE OF TREATMENT CLERK John Doe	
41. SIGNATURE OF RECOVERY CLERK John Doe		42. SIGNATURE OF DISCHARGE CLERK John Doe	
43. SIGNATURE OF DEATH CLERK John Doe		44. SIGNATURE OF BURIAL CLERK John Doe	
45. SIGNATURE OF CREMATION CLERK John Doe		46. SIGNATURE OF INTERMENT CLERK John Doe	
47. SIGNATURE OF MONUMENT CLERK John Doe		48. SIGNATURE OF MAINTENANCE CLERK John Doe	
49. SIGNATURE OF REPAIR CLERK John Doe		50. SIGNATURE OF REPLACEMENT CLERK John Doe	
51. SIGNATURE OF REMOVAL CLERK John Doe		52. SIGNATURE OF RELOCATION CLERK John Doe	
53. SIGNATURE OF RECONSTRUCTION CLERK John Doe		54. SIGNATURE OF REPAIRS CLERK John Doe	
55. SIGNATURE OF REPAIRS CLERK John Doe		56. SIGNATURE OF REPAIRS CLERK John Doe	
57. SIGNATURE OF REPAIRS CLERK John Doe		58. SIGNATURE OF REPAIRS CLERK John Doe	
59. SIGNATURE OF REPAIRS CLERK John Doe		60. SIGNATURE OF REPAIRS CLERK John Doe	
61. SIGNATURE OF REPAIRS CLERK John Doe		62. SIGNATURE OF REPAIRS CLERK John Doe	
63. SIGNATURE OF REPAIRS CLERK John Doe		64. SIGNATURE OF REPAIRS CLERK John Doe	
65. SIGNATURE OF REPAIRS CLERK John Doe		66. SIGNATURE OF REPAIRS CLERK John Doe	
67. SIGNATURE OF REPAIRS CLERK John Doe		68. SIGNATURE OF REPAIRS CLERK John Doe	
69. SIGNATURE OF REPAIRS CLERK John Doe		70. SIGNATURE OF REPAIRS CLERK John Doe	
71. SIGNATURE OF REPAIRS CLERK John Doe		72. SIGNATURE OF REPAIRS CLERK John Doe	
73. SIGNATURE OF REPAIRS CLERK John Doe		74. SIGNATURE OF REPAIRS CLERK John Doe	
75. SIGNATURE OF REPAIRS CLERK John Doe		76. SIGNATURE OF REPAIRS CLERK John Doe	
77. SIGNATURE OF REPAIRS CLERK John Doe		78. SIGNATURE OF REPAIRS CLERK John Doe	
79. SIGNATURE OF REPAIRS CLERK John Doe		80. SIGNATURE OF REPAIRS CLERK John Doe	
81. SIGNATURE OF REPAIRS CLERK John Doe		82. SIGNATURE OF REPAIRS CLERK John Doe	
83. SIGNATURE OF REPAIRS CLERK John Doe		84. SIGNATURE OF REPAIRS CLERK John Doe	
85. SIGNATURE OF REPAIRS CLERK John Doe		86. SIGNATURE OF REPAIRS CLERK John Doe	
87. SIGNATURE OF REPAIRS CLERK John Doe		88. SIGNATURE OF REPAIRS CLERK John Doe	
89. SIGNATURE OF REPAIRS CLERK John Doe		90. SIGNATURE OF REPAIRS CLERK John Doe	
91. SIGNATURE OF REPAIRS CLERK John Doe		92. SIGNATURE OF REPAIRS CLERK John Doe	
93. SIGNATURE OF REPAIRS CLERK John Doe		94. SIGNATURE OF REPAIRS CLERK John Doe	
95. SIGNATURE OF REPAIRS CLERK John Doe		96. SIGNATURE OF REPAIRS CLERK John Doe	
97. SIGNATURE OF REPAIRS CLERK John Doe		98. SIGNATURE OF REPAIRS CLERK John Doe	
99. SIGNATURE OF REPAIRS CLERK John Doe		100. SIGNATURE OF REPAIRS CLERK John Doe	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. LENGTH OF STAY IN lb <u>4 Days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNEL ARUNDEL Gen. Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS 10</u> d. STREET ADDRESS <u>31-L ATKINS</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>GILES</u> Last <u>WILLARD</u>		4. DATE OF DEATH Month <u>4</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-4-1906</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JANITRESS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>A.A. Co - Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>  </u>		13. FATHER'S NAME <u>Tobie Giles</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE CARROLL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or (unknown)) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-30-7147</u>		INFORMANT Address <u>WILLIAM - WILLARD - 31-L ATKINS MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Arteriosclerosis of the arteries</u> (c) <u>Cardiovascular disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) <u>  </u>	(County) <u>  </u>	(State) <u>  </u>
21. I certify that I attended the deceased from <u>Feb 11, 1959</u> to <u>4/23, 1959</u> , that I last saw the deceased alive on <u>4/23/59</u> , 19 <u>  </u> , and that death occurred at <u>11:50 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Ch. E. Hicks</u>		ADDRESS (Street, city or town, state) <u>M.D. 110-CLAY ST ANNAPOLIS MD. 4/25/59</u>			
PHYSICIAN'S NAME (Type) <u>  </u>		DATE SIGNED <u>  </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-27-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BREWER HILL</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks III</u>		ADDRESS <u>ANNAPOLIS - Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

3513

NAME OF DECEASED *John J. Murphy*

RESIDENCE *123 Main St. Boston, Mass.*

DATE OF DEATH *Jan 15 1900*

PLACE OF DEATH *Home*

CAUSE OF DEATH *Heart Failure*

AGE *65*

SEX *Male*

EDUCATION *High School*

OCCUPATION *Engineer*

RELIGION *Catholic*

DATE OF BIRTH *Nov 10 1834*

PLACE OF BIRTH *Irish*

DATE OF MARRIAGE *Mar 10 1860*

NAME OF SPOUSE *Mary J. Murphy*

NAME OF PHYSICIAN *Dr. J. H. Smith*



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3920

## CERTIFICATE OF DEATH

03910

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>24 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2725 Baker Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Evans</b> Middle <b>Williams</b> Last <b>Williams</b>		4. DATE OF DEATH Month <b>4</b> Day <b>17</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1880</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	9. AGE (In years last birthday) yrs. <b>78</b>
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Reuben Williams</b>		14. MOTHER'S MAIDEN NAME <b>Vasma Sanders</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>218-05-7870</b>	
17. INFORMANT <b>Hospital Records</b>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Urinary Uremia</b> DUE TO <b>334X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Phrenic Brain Syndrome Associated to Arterio-sclerosis</b> DUE TO <b>3 weeks - 4 days</b> (c) <b>Hypostatic Pneumonia</b> DUE TO <b>2 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -----		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that I attended the deceased from <b>3/23</b> , 19 <b>59</b> , to <b>4/17</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>4/17</b> , 19 <b>59</b> , and that death occurred at <b>2:32 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>4/17/59</b> ACTUAL SIGNATURE <b>L. Benedict, M. D.</b> M.D. <b>Crownsville State Hospital, Md.</b> <b>4/17/59</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/21/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Holland Funeral</b>		24a. REC'D BY REGISTRAR DATE <b>APR 20 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED

1920

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3921 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03911

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE-ARUNDEL</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>		c. LENGTH OF STAY IN 1b <u>4 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER-SPRING</u> 15-56-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>LAUREL-RACE-TRACK</u>			d. STREET ADDRESS <u>913-NEWHALL-STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>RAYMOND CHARLES WINCHESTER</u>			4. DATE OF DEATH <u>April-2-1959</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/20/16</u>	9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Automobile salesman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Auto.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Raymond Winchester Sr</u>			14. MOTHER'S MAIDEN NAME <u>Violet Pettigrew</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-12-1267</u>		17. INFORMANT <u>Credentials found on deceased</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY-OCCLUSION</u> <u>260X</u> DUE TO (b) <u>DIABETES</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>GUSTAVE-H. FAUBERT, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4/2/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-4-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - Washington D.C.</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 6 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>

FOR STATE  
HEALTH DEPT.

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

SEX

AGE

RACE

EDUCATION

OCCUPATION

RELIGION

Married

Single

Widow

Divorced

Never married

Married

Single

Widow

Divorced

Never married

Married

Single

Widow

Divorced

Never married

Married

Single

Widow

Divorced

Never married

Married

Single

Widow

Divorced

Never married

3021 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

DATE OF DEATH  
TIME OF DEATH  
PLACE OF DEATH

CAUSE OF DEATH  
MANNER OF DEATH

SEX  
AGE  
RACE  
EDUCATION  
OCCUPATION  
RELIGION

Married  
Single  
Widow  
Divorced  
Never married

Married  
Single  
Widow  
Divorced  
Never married

Married  
Single  
Widow  
Divorced  
Never married

Married  
Single  
Widow  
Divorced  
Never married

Married  
Single  
Widow  
Divorced  
Never married

Married  
Single  
Widow  
Divorced  
Never married

Married  
Single  
Widow  
Divorced  
Never married

FOR STATE  
HEALTH DEPT.

3922 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03912

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenland Beach, Baltimore</b> c. LENGTH OF STAY IN 1b <b>3 years</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Same</b> b. COUNTY <b>Same</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Same</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8044 Fort Smallwood Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Bing Fook Wong</b> First Middle Last		4. DATE OF DEATH <b>April 7th.</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Chinese</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/> ?	8. DATE OF BIRTH <b>?</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	11. BIRTHPLACE (State or foreign country) <b>China</b>
12. CITIZEN OF WHAT COUNTRY? <b>China</b>			
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No records</b>		16. SOCIAL SECURITY NO. <b>226-44-6900</b>	
17. INFORMANT <b>Richard Wong and Louis See Door. (chinese)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>?</b> DUE TO (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Gustave H. Faubert, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>4/7/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>April 10/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Longwood</b>		22d. LOCATION (City, town, or county) (State) <b>Boothwyn-Berlin</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Stewart M. Mink</b>		24a. REC'D BY REGISTRAR <b>APR 9 '59</b>	
ADDRESS <b>108 W York-Bell</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	





FOR STATE  
HEALTH DEPT.

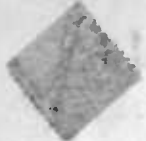
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3923 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03913

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <b>Maryland</b> <b>Same</b> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville</b>		c. LENGTH OF STAY IN 1b <b>one month</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Jumper's Hole Rd.</b>		e. STREET ADDRESS <b>Same</b>	
3. NAME OF DECEASED (Type or print) <b>Samuel Albert Wroy</b>		4. DATE OF DEATH Month <b>April</b> Day <b>1st.</b> Year <b>19 59</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>8/14/25</b>
9. AGE (In years last birthday) <b>33</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Used cars salesman.</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Martin Bros</b>	
13. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>		14. CITIZEN OF WHAT COUNTRY <b>USA</b>	
15. FATHER'S NAME <b>Alfred Wroy</b>		16. MOTHER'S MAIDEN NAME <b>Betty Howard</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		18. SOCIAL SECURITY NO. <b>Unknown</b>	
19. INFORMANT <b>Mrs. Betty Peticord (mother)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic vascular diseases</b> <b>260x</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Diabetes</b> (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Gustave H. Faubert, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>4/2/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-6-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glent Haven</b>		22d. LOCATION (City, town, or county) (State) <b>Glent Burnie Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. V. Singleton</b>		ADDRESS <b>Glent Burnie Md</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Hume</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
3022 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
MEDICINE

11

Name (Printed)		Mills, William	
Age		70 years	
Sex		Male	
Race		White	
Birth Date		Jan. 1, 1890	
Birth Place		Baltimore, Md.	
Usual Residence		Baltimore, Md.	
Cause of Death (Printed)		Heart failure	
Cause of Death (Described)		Sudden	
Time of Death		Jan. 15, 1960	
Place of Death		Home	
Physician (Printed)		Dr. J. H. Jones	
Physician (Signature)		<i>J. H. Jones</i>	
Medical Examiner (Printed)		Dr. J. H. Jones	
Medical Examiner (Signature)		<i>J. H. Jones</i>	
Coroner (Printed)		John J. Jones	
Coroner (Signature)		<i>John J. Jones</i>	
Witness (Printed)		John J. Jones	
Witness (Signature)		<i>John J. Jones</i>	